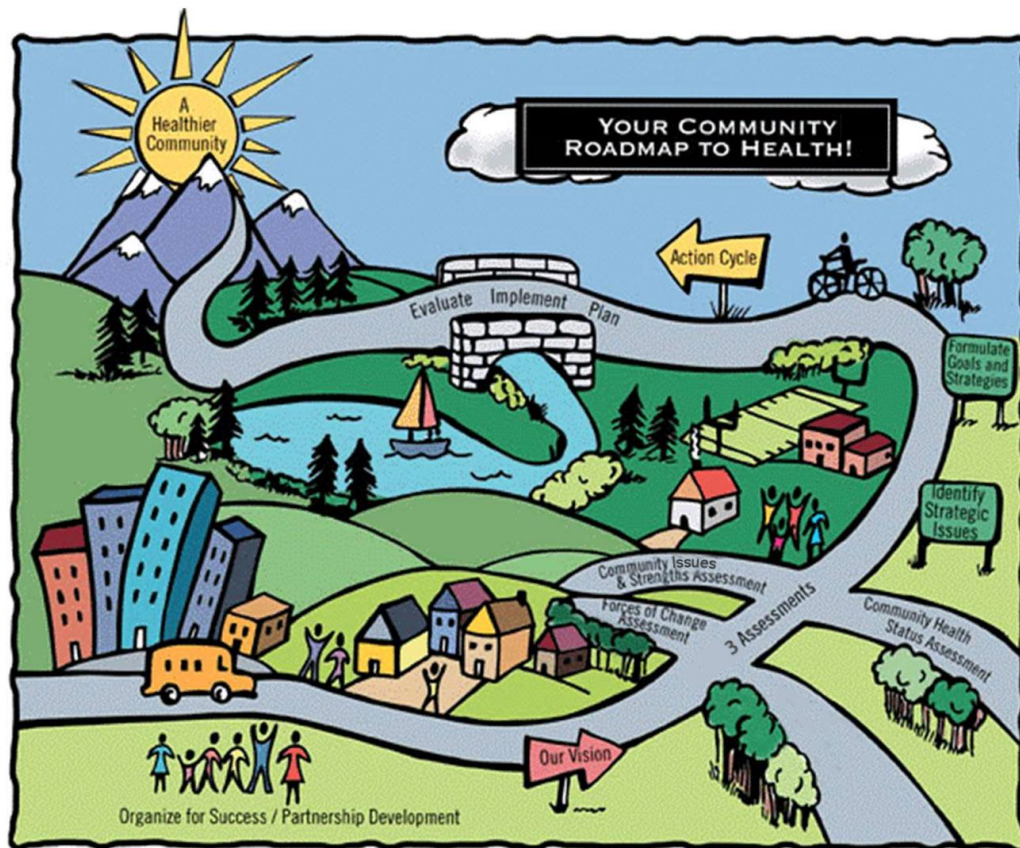


# Healthy South Carolina Initiative Community Engagement Toolkit

April 2014





## **Acknowledgements**

The Community Assessment team would like to thank everyone that contributed to the development of this toolkit.

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Materials have been modified and adapted from the following website:  
National Association of County and City Health Officials (NACCHO)  
<http://www.naccho.org/topics/infrastructure/mapp/>



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## **Introduction**

### **About Us**

The Healthy South Carolina Initiative (HSCI) is a statewide project funded through the Centers for Disease Control and Prevention's Community Transformation Grant Program. HSCI seeks to support programs and strategies that focus on:

- Tobacco free living
- Healthier eating and active lifestyles
- High impact evidence-based clinical and other preventive services
- Health equity, health disparities, and overall health improvement for targeted populations

By focusing on these factors, HSCI community-level efforts reduce chronic diseases such as obesity, heart disease, cancer, stroke, and diabetes.

HSCI is administered by a statewide group that includes the South Carolina Department of Health and Environmental Control (SCDHEC), Eat Smart, Move More South Carolina Coalition (ESMMSC), the South Carolina Tobacco Free Collaborative (SCTFC), the Medical University of South Carolina's Outpatient Quality Improvement Network (OQUIN), and the University of South Carolina, Arnold School of Public Health.

### **Community Engagement**

The Healthy South Carolina Initiative (HSCI) recognizes that each county within South Carolina has its own unique health challenges and each addressed them in different ways. This is demonstrated in South Carolina's obesity epidemic. This issue affects all counties, many of which have formed coalitions and crafted strategic action plans. However, some have not yet started a conversation. This variety in levels of planning and readiness illustrates a need for all to go through a comprehensive planning process. The purpose of this process is to assess residents' health status, document their concerns, and use the information to develop a health improvement plan.

The Healthy South Carolina Initiative Community Engagement Toolkit provides guidance on the community engagement process. HSCI has outlined a process based on models that utilize strategic approaches to community health improvement. An effective process improves health and quality of life through community-wide and community-driven strategic planning. This process is one that:

- Allows communities to identify and use their resources wisely
- Takes into account their unique circumstances and needs
- Facilitates the formation of effective partnerships for strategic action

The community engagement process results in a community-wide strategic plan for public health improvement. For the plan to be carried out, it must be developed through broad input by persons who are committed to the community's health and well-being. It is unlikely that a community will adopt a plan for which they had no input. A community's commitment to carrying out a public health improvement plan will come from the sense of ownership that results from taking part in developing the plan. The Community engagement process focuses on strengthening the entire community rather than separate pieces, bringing together varied interests to prioritize and address the health issues of a community.

### **Who Should Use This Toolkit?**

The toolkit was specifically created for HSCI awardees as a means to fulfill one of their grant requirements, and they are encouraged to work with their Regional DHEC HSCI Coordinator to carry out the recommended activities. However, those not funded through HSCI may find it useful as a model for community organizing and planning.

### **How to Use This Toolkit**

The toolkit provides guidance through a six step process, beginning with the mobilization of community partners, and culminating in the implementation of a comprehensive plan designed to improve the health of the community. Each phase is thoroughly detailed and includes resources, tools and suggestions on how to proceed through each step. The next two pages of the toolkit include a description of policy, systems, and environmental change and a set of minimum requirements that HSCI awardees are expected to address. These requirements should be completed with deliverables for each phase and will help establish readiness and engagement of the community.

# What is Policy, Systems, and Environmental Change?

Policy, systems, and environmental change is a way of modifying the environment to make healthy choices practice and available to all community members. By changing laws and shaping physical landscapes, a big impact can be made with little time and resources. By changing policies, systems and/or environments, communities can help tackle health issues like obesity, diabetes, cancer and other chronic diseases.

<b>Detailed Description of Policy, Systems, and Environmental Change</b>		
Type of Change	Description	Examples
<b>Policy</b>	Includes the passing of laws, ordinances, resolutions, mandates, regulations, or rules	Passing a law allowing residents to plant community gardens in vacant lots; establishing a policy that prohibits junk food in school fundraising drives
<b>Systems</b>	Involves changes made to the rules within an organization	Implementing WIC voucher reimbursement procedures for Farmers' Markets; implementing a healthy lunch program across the state school system
<b>Environmental</b>	A change made to the physical environment	Incorporating sidewalks, paths, and recreation areas into community design

## Why is this important?

Where you live affects how you live, you can't simply make healthy decisions if healthy options aren't available to you. Policy, systems, and environmental changes make healthier choices a real, feasible option for every community member by looking at the laws, rules, and environments that impact our behavior.

<b>What's the Difference Between PSE change and Programs?</b>		
Setting	Programs/Events	Policy, Systems, and Environmental Change
<b>School</b>	Celebrate national nutrition month	Add fruits and vegetables to the cafeteria options in school
<b>Community</b>	Brochure about the dangers of second-hand smoke	Smoke-free workplace law
<b>Worksite</b>	Hold health screenings for staff	Implement a healthy vending machine policy that offers healthy snacks at an affordable price
<b>Hospital</b>	Hold free breastfeeding courses for new moms	Implement steps to become a "baby friendly hospital"

**Minimum Requirements for HSCI Community Assessment Process**

Phase	Minimum Requirements
<b>Phase 1: Organize for Success/Partnership Development</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Recruit a steering committee for the planning process</li> <li><input type="checkbox"/> Identify and recruit partners representative of the community</li> <li><input type="checkbox"/> Orient partners to toolkit</li> <li><input type="checkbox"/> Assess resource needs and secure commitment</li> <li><input type="checkbox"/> Gather previous community assessment and review for gaps</li> <li><input type="checkbox"/> Determine organization and establish timeline</li> <li><input type="checkbox"/> Complete readiness assessment worksheet</li> </ul>
<b>Phase 2: Visioning</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Identify other visioning efforts and make connections as needed</li> <li><input type="checkbox"/> Adopt, amend or create vision and values statements</li> </ul>
<p><b>Phase 3: Three Key Assessment Areas</b></p> <p><i>Assessment 1: Community Voices</i></p> <p><i>Assessment 2: Community Health Snapshot</i></p> <p><i>Assessment 3: Forces of Change</i></p>	<p>Assessment 1:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Choose at least one method for collecting data</li> <li><input type="checkbox"/> Identify resource needs</li> <li><input type="checkbox"/> Plan to include broad representation of input</li> <li><input type="checkbox"/> Compile results into a summary</li> <li><input type="checkbox"/> Share results with committee</li> </ul> <p>Assessment 2:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Review and analyze snapshot data and policies</li> <li><input type="checkbox"/> Compile results into a summary</li> </ul> <p>Assessment 3:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Determine the brainstorming method and convene a session</li> <li><input type="checkbox"/> Complete Threats and Opportunities Worksheet</li> <li><input type="checkbox"/> Summarize key findings from Threats and Opportunities Worksheet</li> </ul> <p>-----</p> <p>Use results from the 3 assessments above to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Create community profile and share with community</li> </ul>
<b>Phase 4: Identify Strategic Issues</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review results from Phase 3 assessments and determine the strategic issues. <i>At least one of your strategic issues should focus on healthy eating, active living, or tobacco free living.</i></li> <li><input type="checkbox"/> Determine the potential impact and likelihood of success for each strategic issue</li> </ul>
<b>Phase 5: Formulating Goals and Strategies</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Summarize key findings into a 1-2 page document and include: key stakeholders involved, brainstorming, assessment data, prioritization and goals and strategies</li> </ul>
<b>Phase 6: The Action Cycle</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Create action plan template with key components: SMART objectives, stakeholders involved, roles and responsibilities for partners, timeframe, and evaluation measures</li> <li><input type="checkbox"/> Create a communication plan for dissemination</li> </ul>

# **Phase 1: Organize for Success/Partnership Development**





## **Phase 1: Organize for Success and Partnership Development**

The first phase of the community planning process is Organize for Success and Partnership Development. The first activity, Organize for Success, begins the community assessment process. Careful groundwork is needed for successful community-wide strategic planning and assessment. It is necessary for key partners to recruit an action oriented steering committee for the community assessment process. Key partners would include the local project team members and leadership from county level grantees for counties that have received HSCI funds. The steering committee includes a broad representation from the community (see Healthy Communities Partnership Inventory). After the steering committee is in place, complete the Readiness Assessment Worksheet.

The second activity of Phase 1, Partnership Development, includes identifying and recruiting partners. Consider partners that give legitimacy to the effort and demonstrate public support. Partners could actively support the process through resources. Partners play a management or leadership role in the planning process. It is important to have in writing the partners' roles and time commitment. The purpose of this phase is to lay out a planning process that will pledge participants' time, commitment, and engagement levels. All of these factors will result in a plan that can be implemented successfully. A list of potential partners can be found at this link:

<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Tip-Sheet-Participant-Identification.pdf>

After reading through this list of potential partners, brainstorm a list of partners for your community with the Healthy Communities Partnership Inventory.





**Phase 1 Worksheet:**

Steps to Success Activities	Leader of Activity	Due Date	Status of Activity
Key partners begin process			
Identify partners from: <ul style="list-style-type: none"> <li>• Multiple towns/cities</li> <li>• Diverse ethnic backgrounds</li> <li>• Groups that represent those most impacted by diseases or health issues</li> </ul>			
Contact all partners, describe the project, and invite them to the first meeting.			
Assess resource needs <ul style="list-style-type: none"> <li>• Staff time</li> <li>• Data collection and information gathering</li> <li>• Meeting space and refreshments</li> <li>• Report production and printing</li> <li>• Educational and training materials</li> </ul>			
Consider how participation will be organized <ul style="list-style-type: none"> <li>• Identify roles, responsibilities, and committees</li> <li>• Formal or informal meetings</li> <li>• Meeting schedules</li> <li>• Flexibility</li> <li>• Time constraints</li> <li>• Length of meetings</li> <li>• Timeline (Timeline template located at the end of this phase)</li> </ul>			
Gather previous community assessment and review for gaps			
Complete Healthy Communities Partnership Inventory			



## Healthy Communities Partnership Inventory

This is a template to brainstorm a list of potential community partners. List the name, email address, and phone number of each organization and/or contact person. Use your core group to identify which of the following associations, organizations or agencies you want to collect more information from.

**Location / Name of Community:** \_\_\_\_\_

**Your Name:** \_\_\_\_\_

<u>Potential Partners by sector</u>	<u>Name(s)</u>	<u>Organization</u>	<u>Position</u>	<u>Contact Information</u> ( <u>phone number and</u> <u>email address</u> )
<b>Child Care Facilities</b>				
<b>Faith-based</b>				
<b>Head Start</b>				
<b>Home</b>				
<b>Private</b>				

<b>Public</b>				
<b>Community</b>				
<b>Concerned Citizens</b>				
<b>Chamber of Commerce</b>				
<b>Businesses &amp; Corporations</b>				
<b>Bike and Pedestrian Coordinators</b>				
<b>Civic Event Groups</b>				
<b>Community Centers</b>				
<b>Community development / planning agencies</b>				
<b>Senior citizen groups and centers</b>				
<b>Elected Governmental Officials &amp; Local Governmental agencies</b>				
<b>Energy Utilities</b>				
<b>Environment/Conservation Groups:</b> (Outdoor Groups: garden, nature watching)				
<b>Ethnic Associations</b>				
<b>Fire &amp; Police Departments</b>				
<b>Food kitchens and emergency housing shelters</b>				

<b>Foundations</b>				
<b>Health &amp; Fitness Groups</b>				
<b>Libraries, Museums</b>				
<b>Local Media:</b> (newspaper, radio, TV)				
<b>Men's and Women's Groups:</b> (cultural, political, social, educational, and vocational)				
<b>Neighborhood associations:</b> (crime watch, block clubs)				
<b>Charities and Service Clubs</b>				
<b>Political/Citizenship Parties:</b> (Democrats, Republicans, League of Women Voters)				
<b>Restaurants and Culinary Groups</b>				
<b>Support/Self-Help Groups:</b> (Weight Watchers, La Leche League)				
<b>Transportation agencies</b>				
<b>YMCAs, Boys &amp; Girls Clubs, etc.</b>				
<b>Youth Groups:</b> (4H clubs, Scouts)				
<b>Faith</b>				
<b>Church Groups, Parish Nurses</b>				

<b>Healthcare</b>				
<b>Local health care systems</b>				
<b>Health centers</b>				
<b>Health Departments, Clinics</b>				
<b>Hospitals</b>				
<b>Public Health Professionals</b>				
<b>Schools</b>				
<b>Education officials:</b> (School districts, school board members, School principals)				
<b>Public &amp; Private Schools</b>				
<b>School Groups:</b> PTA				
<b>School health advocates</b>				
<b>Colleges, Universities, and Trade Schools</b>				
<b>Worksite</b>				
<b>Wellness councils</b>				
<b>Other</b>				



## Timeline

Phases and Description of Activity	Months																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
<b>Organize for Success / Partnership Development</b>																		
<input type="checkbox"/> Determine why the process is needed																		
<input type="checkbox"/> Identify, organize, and recruit participants																		
<input type="checkbox"/> Design the planning process																		
<input type="checkbox"/> Assess resource needs																		
<input type="checkbox"/> Conduct a readiness assessment																		
<input type="checkbox"/> Develop a work plan, timeline, and other tools																		

Phases and Description of Activity	Months																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
<b>Visioning</b>																		
<input type="checkbox"/> Prepare for and design the visioning process																		
<input type="checkbox"/> Hold visioning sessions																		
<input type="checkbox"/> Celebrate successes and achievements to date																		
<b>3 Assessments</b>																		
<b>Community Voices</b>																		
<input type="checkbox"/> Identify subcommittee, approaches, and resources																		
<input type="checkbox"/> Develop / disseminate / and collect data																		
<input type="checkbox"/> Compile results																		
<input type="checkbox"/> Share results																		
<b>Community Health Snapshot</b>																		
<input type="checkbox"/> Review and Analyze the data																		
<input type="checkbox"/> Create summary																		



Phases and Description of Activity	Months																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
<b>Forces of Change Assessment</b>																		
❑ Prepare for the Forces of Change Assessment																		
❑ Hold brainstorming session with committee																		
❑ Simplify list / identify threats and opportunities																		
<b>Identify Strategic Issues</b>																		
❑ Celebrate successes and completion of assessments																		
❑ Create community profile and share with community																		
❑ Identify potential strategic issues																		
❑ Discuss issues-why they are strategic and urgency																		
❑ Consolidate strategic issues																		

# **Phase 2: Visioning**



## **Phase 2: Visioning**

The second phase of the community planning process is Visioning. The Visioning phase will include crafting vision and value statements that will provide focus, purpose, and direction to the community planning process. This phase guides the community through a series of collaborative and creative activities that lead to a shared community vision with common values. If your group is established and has an existing vision, affirm the vision with the new partners.

A vision in the community planning process is an overarching goal for the community – a statement of what the ideal future looks like. An example of a vision statement would be: ***Healthy people living in healthy communities.*** Values are the fundamental principles and beliefs that guide a community-driven planning process.

- **Vision:** WHY we exist: the ultimate way we impact the world.
- **Mission:** WHAT we do: the products or services we provide, to whom and how.
- **Values:** HOW we do our work: ways we behave and treat each other.

### **Sample brainstorming questions for a shared vision:**

- What does a healthy anywhere county mean to you?
- What are important characteristics of a healthy community for all who live, work, and play here?
- How do you envision the community in the next five or ten years?

## Table of Organized Participation and Roles within the Visioning Phase

Below is a table that depicts the type of participation recommended for Phase Two. It is best to keep in mind that each community will have its own unique structure for its organization.

<b>Phase Two: Visioning</b>			
<b>Core Group</b>	<b>Steering Committee</b>	<b>Sub-committees</b>	<b>Community</b>
<ul style="list-style-type: none"> <li>• Plan visioning sessions</li> <li>• Identify and secure session facilitator(s) and engage with them in preparing for visioning session (s)</li> <li>• Summarize the results of the visioning session(s)</li> <li>• Draft vision statement and values</li> </ul>	<ul style="list-style-type: none"> <li>• Oversee and participate in the Visioning phase</li> <li>• Develop a plan for gaining broad community participation and identify community representatives to participate in visioning session(s)</li> </ul>	<ul style="list-style-type: none"> <li>• None recommended; however, a community may designate a sub-committee to conduct the activities in this phase identified for the Core Group</li> </ul>	<ul style="list-style-type: none"> <li>• Broad community participation is essential</li> <li>• Ensure the community receives announcements and updates through a broad spectrum of community mechanisms (media, word of mouth, etc.)</li> <li>• Promote Visioning sessions(s) broadly to encourage community participation</li> </ul>



**Phase 2 Worksheet:**

Steps to Success Activities	Leader of Activity	Due Date	Status of Activity
Identify other visioning efforts and make connections between previous and existing visions			
Design the visioning process ( <i>See Visioning Tip Sheet below</i> ) <ul style="list-style-type: none"> <li>• Who will be invited?</li> <li>• Where will the process be conducted?</li> <li>• What methods will be used to gather information for vision? (e.g. focus groups, town-hall, multi method approach)</li> <li>• How will the values be developed?</li> <li>• How will the information be captured? Who will record the information?</li> <li>• How will the vision be shared with the community?</li> </ul>			
Invite participants and market the visioning session <ul style="list-style-type: none"> <li>• Invitations from steering committee</li> <li>• Formal invitations</li> <li>• Community flyers</li> <li>• Website</li> <li>• Email- distribution lists</li> <li>• Media</li> <li>• Community centers, churches, schools, etc.</li> </ul>			
Finalize vision and value statements and share with community <ul style="list-style-type: none"> <li>• Display on website, flyers, orientation materials, local newspaper, etc.</li> <li>• Remember to refer to vision at subsequent phases of the planning process</li> </ul>			

# Tip Sheet — The Visioning Process<sup>6</sup>

The following is a useful method for structuring community visioning. A similar approach can be used with a committee visioning process. The process details the development of a shared vision, as well as common values.

## **Preparations**

Select a site that can readily accommodate 40-100 persons. Set up the room with participants seated in a circle. This encourages participation by all persons in attendance.

Invitations should be clear and be sent in a timely manner to avoid confusion. Care should be taken to ensure that the time and place facilitate broad attendance. Carefully consider the venue and schedule and how it will accommodate participants with differing schedules or lifestyles.

Key individuals to support the visioning process include: 1) a facilitator who can effectively manage the large group process in a neutral way and 2) one or two note-takers to record the discussion. Recording is a task that should not be assigned or undertaken lightly. The recorder(s) should be skillful at organizing and synthesizing material and should strive to capture the exact wording to the extent possible used by participants. You may also want to designate some individuals to act as observers; these individuals can assure everything is on track and can provide suggestions to the facilitator if needed.

## **Welcome/Introduction**

Set the tone of the visioning session by greeting participants when they arrive, arranging for clear signage, and offering light refreshments. Helping people feel comfortable upon arrival and communicating to participants the importance of their presence can go a long way toward building trust and commitment.

The facilitator or a steering committee representative should open the meeting with an explanation of the planning process and why a visioning process is important. The list of benefits cited in the Visioning guidance can be a useful reference. Be sure to emphasize that the goal is to create a shared vision for the community and not a vision for any one organization.

## **Building Rapport/Icebreaker**

After the introduction, a small amount of time should be dedicated to building rapport among the participants. Everyone in the room should be given a chance to introduce themselves. Consider having participants engage in icebreaker exercises; these can help to ease tension in the room and get everyone comfortable. Icebreaker activities might include the following.

1. As people introduce themselves, ask them to state their expectation for the meeting. They can also be asked to state a "fun fact" about themselves, to help ease the tension.

2. Since all of the participants may not know each other well, participants can be divided into groups of 2-4 to "chat" for 10 minutes, and then return to the larger group to introduce each other.

### **Vision Brainstorming and Development**

Once participants are comfortable with the topic and with each other, the dialogue should be moved toward discussing a vision for the community. Questions should be formulated beforehand to drive this discussion. Useful visioning questions might include:

1. What does a healthy Anywhere County mean to you?
2. What are important characteristics of a healthy community for all who live, work, and play here? and
3. How do you envision the community in the next five or ten years?

Responses to these questions should focus on broad concepts; not details. Responses can be collected through brainstorming activities or by writing ideas down and then sharing them. The group can be organized to gather information through small group processes, or the questions can be addressed by the group as a whole.

Possible approaches for brainstorming include:

- Ask each person to write down what they believe about healthy communities. Then ask participants to pair up, share their thoughts, and develop a joint list. Participants should clarify each other's ideas and discuss any conflicting information. Then each pair can join another pair and repeat the process. The process is repeated until the entire group is back together.
- Ask each participant to write down their ideas. Then, in round-robin fashion, go around the room, posting all ideas on a flip chart (this can be shortened by limiting the number of ideas offered). After all ideas are shared, the group discusses and organizes them.
- Distribute small pieces of paper and ask participants to write down their ideas — one idea on each piece of paper. Then have participants tape their ideas to a wall. A small group then moves the ideas around until common ideas are grouped together. List and discuss the common ideas.

### **Values Brainstorming and Development**

Once many ideas have been gathered and there is consensus about the concepts contained in a community vision, the group can move on to identifying common values (this may be done in the second part of the first session, or during a second session). It is strongly recommended that the actual drafting of the vision statement be done by a small task force or staff group.

The values brainstorming process should be similar and can use the same brainstorming techniques.

Questions to elicit thoughts on common values include:

1. Taking into consideration the shared vision that has been developed, what are the key behaviors that will be required of the local public health system partners, the community, and others in the next five to ten years to achieve the vision?

2. What type of working environment or climate is necessary to support participants in performing the above behaviors and in achieving the vision?

### **Closing the Session /Check-out**

At the end of each session, the facilitator should ensure that everyone is comfortable with the results of the session. Give participants a chance to make final comments or express concerns about the results or the process. This helps to ensure that participants leave the session without feeling frustrated and may also improve future group processes. Close the meeting with a discussion of next steps. Discuss the need for and timing of future meetings. Make sure everyone understands the next steps and how follow-up will occur.

### **Follow-up to the Session**

After the visioning session, a small group should compile the results and draft statements for the shared vision and common values. The draft statements should be presented to the visioning group participants (through a follow-up session or through other mechanisms). Participants should be given a chance to make minor adjustments.

Once everyone is satisfied with the vision and values, each should be formally adopted. The statements should then be kept alive through the remainder of the planning process. All materials, such as brochures, leaflets, and reports, should include the statements. References to vision and values statements should be made at the beginning of each committee meeting.



# **Phase 3:**

## **Three Key Assessments**

**Assessment 1:**

**Community Voices**

**Assessment 2:**

**Community Health Snapshot**

**Assessment 3:**

**Forces of Change**



### **Phase 3: Three Key Assessments**

The three key assessments form the groundwork of the community assessment process. Collectively, these assessments have several purposes:

- Provide insights on the gaps between current conditions and a community's visions (as established in the Visioning phase)
- Provide information to use in identifying the strategic issues that must be addressed to achieve the vision
- Serve as the main source of information from which the strategic issues, strategies and goals are built

Implementing the key assessments should be done in a structured and coordinated way. There is no definite order in which to carry out the three assessments. It is important to have committees for the Community Voices and Community Health Snapshot assessments. This will ensure that the assessments are completed in an effective and efficient way. Broad participation is critical to the effectiveness of all three assessments. Members on each committee should have skills that will aid in the completion of the assessment. Members of committees can overlap and facilitate the sharing of information. It is essential to bridge the results of each assessment to gain insight into the issues facing the community. For example, the Community Voices assessment may identify additional health indicators that should be reviewed in the Community Health Snapshot assessment. Both of these assessments could lead to the revelation of potential threats and opportunities in the Forces of Change assessment. These assessments will lead to the discovery of strategic issues in the community.

It is important in this process to celebrate successes. After each assessment is finished, the committees should recognize their achievements. Conducting these time-consuming assessments can be difficult, but enforcing success will engage the community in the process.

## Table of Organized Participation and Roles within the Three Key Assessments Phase

Below is a table that depicts the type of participation recommended for Phase Three. It is best to keep in mind that each community will have its own unique structure for its organization

Phase Three: Three Key Assessments				
	Core Group	Steering Committee	Sub-committees	Community
	See details below for each assessment.	See details below for each assessment.	See details below for each assessment.	See details below for each assessment.
Community Health Snapshot	<ul style="list-style-type: none"> <li>• Support Steering Committee and sub-committee activities</li> <li>• Assist with data collection and analysis, community health profile development, and broad presentation and distribution of assessment results to community.</li> <li>• Ensure connectivity between methods and promotion of all assessments.</li> </ul>	<ul style="list-style-type: none"> <li>• Oversee sub-committee activities</li> <li>• Identify data sources for sub-committee.</li> <li>• Select locally appropriate indicators.</li> <li>• Provide input into Community Health Profile development.</li> </ul>	<ul style="list-style-type: none"> <li>• Sub-committee, with expertise in data, should oversee the community health snapshot.</li> <li>• Engage community members to participate in community health snapshot planning and completion.</li> <li>• Collect and analyze data.</li> <li>• Develop Community Health Profile.</li> <li>• Present and distribute assessment results to community.</li> </ul>	<ul style="list-style-type: none"> <li>• Present and distribute the Community Health Profile throughout the community.</li> <li>• Involve community in the community health snapshot sub-committee; additional community participants may be recruited if desired.</li> </ul>
Community Voices	<ul style="list-style-type: none"> <li>• Support Steering Committee and sub-committee activities</li> </ul>	<ul style="list-style-type: none"> <li>• Oversee sub-committee activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Form sub-committee with expertise in community engagement, knowledge of community, and in data collection and analysis, oversee the community voices.</li> </ul>	<ul style="list-style-type: none"> <li>• Broad community participation is essential.</li> <li>• Promote broad community participation in all assessment activities.</li> </ul>

### Phase Three: Three Key Assessments

	Core Group	Steering Committee	Sub-committees	Community
<b>Community Voices</b> continued	See details below for each assessment.	See details below for each assessment.	See details below for each assessment.	See details below for each assessment.
	<ul style="list-style-type: none"> <li>• Ensure connectivity between methods and promotion of all assessments.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide recommendations for gaining broad community participation in assessment.</li> <li>• Participate in activities as needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Engage community members to participate in community voices planning and implementation and to provide feedback.</li> <li>• Prepare for community voices activities and ensure effective implementation.</li> <li>• Oversee implementation of activities.</li> <li>• Compile results.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure the community receives announcements and updates through a broad spectrum of community mechanisms (media, word of mouth, etc.).</li> <li>• Ensure participation of community members representing the diversity of the community, including those disproportionately affected by poor health outcomes or community conditions.</li> </ul>
<b>Forces of Change</b>	<ul style="list-style-type: none"> <li>• Prepare for and plan brainstorming session(s)</li> <li>• Identify and secure session facilitator(s) and engage with them in preparing for visioning session(s).</li> <li>• Summarize and compile the assessment results.</li> <li>• Ensure connectivity</li> </ul>	<ul style="list-style-type: none"> <li>• Entire committee should participate in brainstorming session(s) to identify influential forces.</li> <li>• Identify opportunities and threats for each force.</li> </ul>	<ul style="list-style-type: none"> <li>• None recommended; however, some Steering Committees may want to designate a forces of change sub-committee to conduct the responsibilities identified for the Core Group.</li> </ul>	<ul style="list-style-type: none"> <li>• Broad community participation is essential.</li> <li>• Engage community members in the forces of change sub-committee; additional community participants may be recruited if desired.</li> </ul>



## Planning to Assess: “Are you ready?” Worksheet

The assessment and planning process brings together key partners to start the dialogue to improve the health status of your community. The benefits of going through this process include:

- Improved communication with key partners
- Identifying assets in the community
- A realistic strategic work plan based on community input.

<b>Critical Elements:</b>	Yes	No*
1. Group/coalition has diverse individuals and/or organizations that will give time and resources		
2. Group/coalition has volunteers, funding/in-kind, and supplies to do a local assessment		
3. Scope of the assessment is reasonable ( <i>What we are going to measure? &amp; How we are going to gather information</i> )		
4. Technical support is available for collecting and analyzing data, facilitating meetings, preparing reports for the public, and public speaking		
5. Group/coalition has identified a person ( <i>not necessarily the chair</i> ) who will coordinate assessment activities		
6. Individuals’ roles and responsibilities in the assessment/planning process are clear		
7. Method of gathering community input ( <i>survey, focus group, etc.</i> ) has been determined		
8. Group/coalition has a document showing: <ul style="list-style-type: none"> <li>• Timeline for assessment activities</li> <li>• Specific activities that will be conducted</li> <li>• Who is involved in the specific activities</li> </ul>		

\*If a response is “No” for one or more critical elements please contact HSCI project team members for technical assistance



<b>Assessment 1: Community Voices</b>
---------------------------------------

The Community Voices assessment gathers the thoughts, opinions and concerns from community members. This information leads to a portrait of the community as seen through the eyes of its residents. Listening to and communicating with the community are essential to any community-wide initiative. Mobilizing and engaging the community may be a daunting task. However, when successful, it ensures greater sustainability and enthusiasm for the process. It is recommended that this assessment is done first in order to obtain a broad view of community needs.

**Phase 3 -Assessment 1 Worksheet:**

Steps to Success Activity	Leader of Activity	Due Date	Status of Activity
Choose at least one method for collecting data Methods include: <ul style="list-style-type: none"> <li>• Survey</li> <li>• Photo voice</li> <li>• Community Forum</li> <li>• Key Leader Interviews</li> <li>• Focus group</li> </ul>			
Identify resource needs such as: <ul style="list-style-type: none"> <li>• Survey instrument development and dissemination</li> <li>• Meeting space</li> <li>• Travel costs</li> <li>• Staff time</li> <li>• Advertising</li> <li>• Marketing</li> </ul>			
Collect data <ul style="list-style-type: none"> <li>• Ensure broad representation of input</li> </ul>			
Compile results into a summary			
Share results with committee			

**Resources (Below):**

- Key informant guide
- Sample list of key informants
- Photo voice manual
- Focus group tip sheet
- Sample Survey Template
- Conducting Community Forums - [http://ctb.ku.edu/en/tablecontents/sub\\_section\\_main\\_1021.aspx](http://ctb.ku.edu/en/tablecontents/sub_section_main_1021.aspx)

**Key Informant Interviews Guide:**

*Getting the Lay of the Land On Health: A Guide for Using Interviews to Gather Information* is designed to help users determine when and how to use key informant interviews as a means of gathering information.

[http://www.accessproject.org/adobe/getting\\_the\\_lay\\_of\\_the\\_land\\_on\\_health.pdf](http://www.accessproject.org/adobe/getting_the_lay_of_the_land_on_health.pdf)

**Sample List of Key Informants by Community Sector**

This document shows the categories and sectors from which key informants were chosen for the 2010 community themes and strengths assessment report for Knox County, TN

<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/loader.cfm?csModule=security/getfile&pageid=179861>

**Photo voice Manual:**

Photo voice is a participatory data gathering process which combines photography with grassroots action. The process can be used to gain insight into how community members identify their circumstances. Photo voice has three goals. It enables people to record and reflect their community's strengths and problems. It promotes dialogue about important issues through group discussion and photographs. Finally, it engages policymakers.

<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Photovoice-Manual.pdf>

**Tip Sheet – A Step-by-Step Approach to Conducting a Focus Group<sup>1</sup>**

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<sup>1</sup> Academy for Educational Development. *A Skill-Building Guide for Making Focus Groups Work*. Washington, DC: 1995.

Below is a brief outline of the eight steps recommended in focus group research. The use of focus group resources or guidebooks to ensure effective implementation.

1. Decide if focus groups are the right tool for you to get the information you need. Focus groups are useful if: the discussion among participants will help provide insight, the group atmosphere will stimulate honest response, the discussion can be limited to well-defined topics, and the logistics can be managed.
2. Determine who should participate in your focus group(s). Consider factors such as social class, life cycle, user and nonuser status, age, culture, literacy/formal education, etc.
3. Draft a screening questionnaire to help recruit and place participants.
4. Develop a topic guide. There are four primary stages of the focus group discussion; the topic guide should follow this basic flow:
  - A. Introduction – The moderator provides an overview of the goals of the discussion and introductions are made. (Approximately 10 minutes.)
  - B. Rapport Building Stage – Easily answered questions are asked to encourage participants to begin talking and sharing. (Approximately 10 minutes.)
  - C. In-depth Discussion – The moderator focuses on the main questions in the topic guide, encouraging conversation that reveals participants' feelings and thoughts. (Approximately 60 minutes.)
  - D. Closure – The moderator summarizes the impressions or conclusions gathered and participants clarify, confirm, or elaborate on the information. (Approximately 10 minutes.)
5. Design forms for the moderator and note taker to use. The moderator may want a summary sheet with a reminder of key information about participants. The recorder (which all focus groups should have) can use forms with the focus group questions on it or another option is a two-column format organizing comments and quotes in one column and observations and interpretations in the second.
6. Draft a self-evaluation form. The self-evaluation form can help the moderator to improve his/her skills over time.
7. Practice a focus group discussion in advance so that everything will run smoothly. Then, conduct the focus group(s), being sure to tape them so that everything is captured.
8. Organize your notes for the focus group report. After conducting the focus group(s), the moderator and note-taker should review notes to fill in gaps and ensure accurate and complete information has been gathered. Keep a list of participants who were at the focus group sessions (i.e., have a sign-in sheet) so that you can keep them informed about next steps and gather additional feedback.



# Sample Survey

This survey has been developed to get your opinions about health issues in our community. The results will be used to identify issues we can address through community action. Your individual responses will be kept confidential. If you have already filled out this survey please do not complete again.

---

1. What county do you live in?

---

2. My zip code is:

---

3. Age    18-25    26-39    40-54    55-64    65 or older

---

4. Gender    Male    Female

---

5. Race:

African American/Black    Asian/ Pacific Islander    Native American  
 Caucasian    More than one    Other (5a) \_\_\_\_\_

---

6. I am Hispanic/Latino.    Yes    No

---

7. My Job Status:

Employed    Unemployed    Working Student    Full-time Student    Homemaker  
 Unable to work    Retired    Other (7a) \_\_\_\_\_

---

8. My Household Income (in \$) is:

Less than \$25,000    25,000-39,999    40,000-59,999    60,000-79,999    80,000-99,999    100,000 or more

---

9. Highest level of education:

Did not finish high school    High School or GED    Technical College    Bachelors    Masters    Doctorate  
 Other (9a) \_\_\_\_\_

---

10. I have this type of health care coverage.

Private Insurance    Medicaid    Medicare    No Insurance    Other (10a) \_\_\_\_\_

---

11. I have been diagnosed by a doctor, nurse, or other health care provider with the following. (Check all that apply.)

High blood pressure    High blood sugar (Diabetes)    High cholesterol    None of the above

---

12. My main form of transportation is

Bicycle    Bus    Car    Taxi    Walk   Other (12a) \_\_\_\_\_

---

---

**13.** I think these are 3 main reasons why people in our community do not seek health care:

- Cannot get time off       Do not know where to go       Hours not convenient  
 No family doctor       No insurance       No one to keep children  
 No way to get there       Not sick       Other (please specify) (13a) \_\_\_\_\_
- 

**14.** I think these are 3 main reasons that prevent people from being physically active in our community:

- Crime       Heat/Cold       No community events       No street lights  
 No parks/outdoor spaces       Not enough bike lanes       Not enough sidewalks       Personal Choice  
 Stray dogs/animals       Traffic       Too tired after working  
 Other (14a) \_\_\_\_\_
- 

**15.** I think these are 3 main reasons that prevent people in our community from eating healthy foods:

- Don't cook at home       Eat fast food regularly       No community gardens  
 No farmer's market       No grocery stores nearby       Stores don't accept SNAP/EBT/WIC  
 Stores don't have quality produce       Too expensive       Too tired after work  
 Other (15a) \_\_\_\_\_
- 

**16.** I think these are the 3 most important health concerns in our community:

- Alcohol Use       Alzheimer's/Dementia       Arthritis       Cancer       Diabetes  
 Drug Use       Heart Disease/Stroke       High Blood Pressure       HIV/AIDS/STDs  
 Infant Death       Mental Health       Overweight/Obesity       Tobacco Use  
 Other (please specify) (16a) \_\_\_\_\_
- 

**17.** I think these are the 3 most important factors for a health community:

- Acceptance of all people       Access to affordable health care       Access to healthy and affordable food  
 Access to safe and affordable housing       Access to safe places to be active       Clean environment  
 Good jobs/healthy economy       Good schools       Low crime  
 Low disease rates       Neighbors helping neighbors       Smoke free workplaces  
 Strong faith and fellowship       Other (please specify) (17a) \_\_\_\_\_
- 

**18.** I would rate the overall health of our community as:       Poor       Fair       Good       Very Good       Excellent

---

**19.** I use the following tobacco products (check all that apply).

- I don't use tobacco products  
 Chew tobacco, dip, snuff, or snus       Cigarettes       Cigars or Little Cigars       Pipe  
 Other tobacco product(s) (19a) \_\_\_\_\_
- 

**20.** I agree with the idea of smoke free workplaces, including restaurants and bars.       Yes       No

---

**21.** I am exposed to secondhand smoke.       Yes       No

---

**22.** If yes, where (check all that apply)?       Vehicle       Home       Work       Other

---

**23.** In the last 2 days, how many fruits and vegetables have you eaten?       None       1-2       3-4       5 or more

---

**24.** In the last week, how many times were you physically active?       None       1-2       3-4       5 or more

---

**25.** How important is it to eat fruits and vegetables?       Not Important       Important       Extremely Important

---

---

26. How important is it to be physically active?       Not Important     Important     Extremely Important

---

27. In the last 30 days when I bought fruits and vegetables, they were (check all that apply):       Fresh     Frozen     Canned     Can't afford to buy

---

**Thank you for taking time to complete this survey.**



<b>Assessment 2: Community Health Snapshot</b>
--

The Community Health Snapshot provides important data on health indicators. This data includes those groups of people that are impacted by different diseases and conditions. It also includes policy and environmental scans that impact health. Communities may choose to look at additional indicators.

Examining this snapshot data and policies will help you:

- Assess changes over time
- Reveal differences among population subgroups or with peer, state, or national data
- Identify priority health issues

This toolkit provides county health data, healthy eating and active living environmental scans, and tobacco policy and environmental scans. The healthy eating and active living environmental scans can be found on the next page of this document. The tobacco policy and environmental scans will be provided.

**Phase 3-Assessment 2 Worksheet:**

Steps to Success Activities	Leader of Activity	Due Date	Status of Activity
Review current snapshot data and policies			
Examine data by: <ul style="list-style-type: none"> <li>● Gender</li> <li>● Age</li> <li>● Race</li> <li>● Economic</li> <li>● Death and disease</li> </ul>			
Select the data that most concerns the committee  The summary report can be presented in several different formats: <ul style="list-style-type: none"> <li>● Written report (One pager)</li> <li>● PowerPoint presentations</li> </ul>			

**Healthy Eating and Active Living (HEAL) Environmental Scan**

The following links will help in the search of healthy eating and active living initiatives going on in your community.

**County Nutrition, Physical Activity and Profile Sheets**

<http://www.scdhec.gov/health/chcdp/obesity/data.htm>

**Does your community have Complete Streets and/or a Master Plan to support walking and biking?**

Find out more at: Palmetto Cycling Coalitions

<http://www.pccsc.net/policies.php>

**Where are the Farmer's Markets in my community?**

<https://agriculture.sc.gov/DisplayList.aspx?ContactListID=4>

**What schools in my community participate in Safe Routes to School?**

<http://www.scsaferoutes.org/partnership/current-partners>

**Are there schools in my community that participate in Farm to School?**

[http://agriculture.sc.gov/userfiles/file/Farm%20%20School/Participation%20Map%20\(1\).pdf](http://agriculture.sc.gov/userfiles/file/Farm%20%20School/Participation%20Map%20(1).pdf)

<http://agriculture.sc.gov/userfiles/file/Farm%20%20School/Participation%20Map%202012.pdf>

**Are there Mother Friendly Employers in my community?**

<http://scbreastfeedingcoalition.org/employers/sc-mother-friendly-employers/>

**Is my hospital Baby Friendly?**

<http://scbreastfeedingcoalition.org/healthcare/baby-friendly-hospital-initiative/sc-ten-steps-program/sc-ten-steps-award-winners/>



**Assessment 3: Forces of Change**

The Forces of Change assessment identifies factors such as employment, legislation, technology, and other impending changes in our community. This assessment results in a list that identifies the key forces and their impacts. During this assessment, the committee brainstorms to identify forces in four common categories: Political, Economic, Social, and Technological (PEST). Other categories can include environmental, scientific, legal, education and ethical factors.

**Phase 3-Assessment 3 Worksheet:**

Steps to Success Activities	Leader of Activity	Due Date	Status of Activity
Determine the brainstorming method (e.g. round robin, brainstorming) that will be used to collect Forces of Change information <ul style="list-style-type: none"> <li>• Identify a facilitator</li> <li>• Identify a note taker</li> <li>• Find a convenient location</li> <li>• Prepare materials and questions for facilitator (Brainstorming Tool and Threats &amp; Opportunities Worksheet)</li> </ul>			
Invite steering committee members and other leaders in the community. Participants should be: <ul style="list-style-type: none"> <li>• “big picture” thinkers, “movers and shakers”</li> <li>• aware of the important social, economic, and political trends</li> </ul>			
Complete Forces of Change Brainstorming Tool			
Compile and synthesize results <ul style="list-style-type: none"> <li>• Complete Threats &amp; Opportunities Worksheet</li> </ul>			
Create community profile using guidelines provided and share with community			

## **Forces of Change Brainstorming Tool<sup>2</sup>**

The following two-page tool is designed for committee members to use in preparing for the Forces of Change brainstorming session.

### **What are Forces of Change?**

**Forces are a broad all-encompassing category** that includes trends, events, and factors.

- **Trends are patterns over time**, such as migration in and out of a community or a growing disillusionment with government.
- **Factors are discrete elements**, such as a community's large ethnic population, an urban setting, or a jurisdiction's proximity to a major waterway.
- **Events are one-time occurrences**, such as a hospital closure, a natural disaster, or the passage of new legislation.

### **What Kind of Areas or Categories Are Included?**

Be sure to consider any and all types of forces, including:

- social
- economic
- political
- technological
- environmental
- scientific
- legal
- ethical
- education

### **How to Identify Forces of Change**

Think about forces of change — outside of your control— that affect the community.

1. What has occurred recently that may affect our local public health system or community?
2. What may occur in the future?
3. Are there any trends occurring that will have an impact? Describe the trends.
4. What forces are occurring locally? Regionally? Nationally? Globally?
5. What characteristics of our jurisdiction or state may pose an opportunity or threat?
6. What may occur or has occurred that may pose a barrier to achieving the shared vision?

Also, consider whether or not forces identified were previously discussed.

1. Was the assessment process spurred by a specific event such as changes in funding or new trends in public health service delivery?
2. Did brainstorming discussions during the Visioning or Community Voices phases touch upon changes and trends occurring in the community?

## Forces of Change Brainstorming Tool (Page 2)

Using the information from the previous page, list all brainstormed forces, including factors, events, and trends. Continue onto another page if needed. Bring the completed worksheet to the brainstorming session

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

11. \_\_\_\_\_

12. \_\_\_\_\_



**Forces of Change - Threats and Opportunities Survey<sup>3</sup>**

The major categories are identified in the left-hand column (“Forces”). Then, for each category, identify the threats and opportunities for the public health system or community created by each. Continue onto another page if needed. You may include addition forces.

<b>Forces (Trend, Events, Factors)</b>	<b>Threats Posed</b>	<b>Opportunities Created</b>
<b>Social</b>		
<b>Economic</b>		
<b>Political</b>		
<b>Technological</b>		
<b>Environmental</b>		
<b>Scientific</b>		

<b>Legal</b>		
<b>Ethical</b>		
<b>Education</b>		

**Forces of Change- Threats and Opportunities Survey Works (Example)**

The major categories are identified in the left-hand column (“Forces”). Then, for each category, identify the threats and opportunities for the public health system or community created by each. Continue onto another page if needed. You may include addition forces.

Forces (Trend, Events, Factors)	Threats Posed	Opportunities Created
Social	<ol style="list-style-type: none"> <li>1. Poverty level in rural areas</li> <li>2. Access to services &amp; information</li> <li>3. Health disparities</li> </ol>	<ol style="list-style-type: none"> <li>1. Charitable programs</li> <li>2. Community outreach programs</li> <li>3. Agency partnerships/ health fairs</li> </ol>
Economic	<ol style="list-style-type: none"> <li>1. Affordability of medical/medicine</li> <li>2. Budget cuts, State funding</li> <li>3. Staffing issues (short staff)</li> </ol>	<ol style="list-style-type: none"> <li>1. Cross training work force</li> <li>2. Organization collaboration on funding</li> <li>3. Lottery money for education funding</li> </ol>
Political	<ol style="list-style-type: none"> <li>1. Debate on Medicare/National healthcare system</li> <li>2. Action on diversity, Bio-terrorism and war</li> </ol>	<ol style="list-style-type: none"> <li>1. Good support from political representatives</li> <li>2. Political representatives engaged in community events and major issues</li> </ol>

Technological	<ol style="list-style-type: none"> <li>1. Limited access and inability to afford computers technology</li> <li>2. Increase illiteracy of technology</li> <li>3. Information lost due to system down</li> </ol>	<ol style="list-style-type: none"> <li>1. Telecommunication abilities</li> <li>2. Computer monitor and tracking system in rural areas</li> <li>3. Mobile technology centers for rural areas</li> </ol>
Environmental	<ol style="list-style-type: none"> <li>1. Poor housing conditions</li> <li>2. High crime areas</li> <li>3. Land use development</li> </ol>	<ol style="list-style-type: none"> <li>1. Programs to improve air, water, and housing qualities</li> <li>2. Grants to create new building and remodeling old homes</li> </ol>
Scientific	<ol style="list-style-type: none"> <li>1. Limited access and affordability of breakthrough scientific medical procedures and research</li> </ol>	<ol style="list-style-type: none"> <li>1. Use of scientific data/research to make better decisions for the community</li> </ol>

<p>Legal</p>	<ol style="list-style-type: none"> <li>1. Inability to afford legal services</li> <li>2. Protection of client and employee information</li> </ol>	<ol style="list-style-type: none"> <li>1. HIPPA</li> <li>2. Adequately enforcing laws to protect the best interest of the community</li> </ol>
<p>Ethical</p>	<ol style="list-style-type: none"> <li>1. Providing different levels of care according to social economic class</li> <li>2. Disregard to ethical standards</li> </ol>	<ol style="list-style-type: none"> <li>1. Expectation of trust, honesty, and integrity by employers</li> <li>2. Adhere to the organization's ethical standards (medical, professional, and personal)</li> </ol>
<p>Education</p>	<ol style="list-style-type: none"> <li>1. Funding cut for programs</li> <li>2. Increase illiteracy rate</li> <li>3. Decrease community &amp; parental support</li> </ol>	<ol style="list-style-type: none"> <li>1. Developing programs to expand services to rural areas</li> <li>2. Health fairs, partnerships &amp; collaboration to educate the community on health disparities</li> </ol>

# Community Profile Guideline Questions

Please use the following questions to guide the creation of your community profile.

- 1. What are the top concerns from the community based on the Community Voice Assessment?**
- 2. What is the main health issue(s) facing your community based on the Community Health Snapshot Assessment?**
- 3. What are the health indicators and/or gaps in policies that have caught your community's attention?**
- 4. In the Forces of Change Assessment, what are the main factors impacting your community?**

# Supplemental Materials

The supplemental material and links located on the next few pages will help aid in conducting phase three of this process. Please review and use components as needed.

## Supplemental Links

### **Community Health Status Report: Fayette County 2011**

This is an example of a final community health assessment report for Lexington Fayette County Health Department.

<http://www.lexingtonhealthdepartment.org/Portals/0/strategic%20community%20plans/CommHealthStatusReport06292012.pdf>

### **Community Assessment Report -Lexington-Fayette County Health Department**

This document is a compilation of all of the community assessment information that has been compiled at the Lexington-Fayette County Health Department and will serve as the foundation for the community health improvement plan for the Lexington-Fayette County area.

[http://www.lexingtonhealthdepartment.org/Portals/0/strategic%20community%20plans/Community%20Assessment%20Report\\_FINAL%205-14-12.pdf](http://www.lexingtonhealthdepartment.org/Portals/0/strategic%20community%20plans/Community%20Assessment%20Report_FINAL%205-14-12.pdf)

### **Healthy Capital Counties 2012 Indicators**

This is an explanation of how to identify strategic issues/ indicators and how to organize them into a meaningful inventory.

[http://www.healthycapitalcounties.org/uploads/9/1/6/3/9163210/2012\\_indicators\\_final\\_table.pdf](http://www.healthycapitalcounties.org/uploads/9/1/6/3/9163210/2012_indicators_final_table.pdf)

## Kershaw County Indicator Inventory

The indicator inventory is a tracking device used to organize and potentially monitor health indicators of interest to your community as it pertains to both outcomes and measures.

HEALTH FACTORS & OUTCOMES	INDICATOR GROUPS		INDICATORS/MEASURES	KC	SC	US	SOURCE/YEAR
Physical Environment	Environmental Quality	Drinking Water Safety	Percentage of population exposed to water exceeding a violation limit during the past year (2% Weight in health factors)	4%	2%	0%	CHR, Safe Drinking Water Information System, FY 2012
		Access to Recreational Facilities	Rate of recreational facilities per 100,000 population	6	9	16	CHR, County Business Patterns, 2010
			Percentage of population living within half a mile of a park	11%	14%	--	CHR, CDC Tracking Program 2010
Healthy Foods	Percent of all restaurants that are fast-food establishments (2% Weight in health factors)	Percent of population who are low-income and do not live close to a grocery store. (2% Weight in health factors)	55%	49%	27%	CHR, County Business Patterns 2010	
			7%	8%	1%	CHR, USDA, 2012	
Social and Economic Factors	Income and Poverty	Poverty	Percent of children under age 18 in poverty (10% weight in health factors)	27%	28%	14%	CHR, SAIPE, 2011
			Percent of persons below poverty level	15.8%	17%	--	US Census Bureau, 5 yr est. (2007-2011)
			Percent of children enrolled in public schools that are eligible for free lunch	48%	48%	--	CHR, NCES 2011
			WIC enrollment need met (pregnant women)	44%	42%	--	DHEC, PHSIS 2012
			WIC enrollment need met (infants)	121%	121%	--	DHEC, PHSIS 2012
			WIC enrollment need met (children)	48%	52%	--	DHEC, PHSIS 2012
		Median household income	Median annual household income	\$41,055	\$42,477	--	CHR, SAIPE 2011



HEALTH FACTORS & OUTCOMES	INDICATOR GROUPS		INDICATORS/MEASURES	KC	SC	US	SOURCE/YEAR
	Education	High school graduation	Percent of ninth grade cohort that graduates in 4 years (5% weight in health factors)	73%	74%	--	CHR, SC State Dept of Ed, 2010-2011
		College education	Percent of adults aged 25-44 years with some post-secondary education (5% weight in health factors)	55%	58%	70%	CHR, ACS 5yr, 2007-2011
	Employment	Unemployment	Percent of population age 16+ unemployed but seeking work (10% weight in health factors)	9.5%	10.3%	5%	CHR, LAUS, 2011
		Commuting	Percent of the workforce that drives alone to work	81 %	83%		CHR, ACS 2007-2011
	Community Safety	Crime	Violent crime rate per 100,000 population (5% weight in health factors)	508	667	66	CHR, UCR, 2008-2012
			Deaths due to homicide per 100,000 population	7	8	--	CHR, NVSS 2004-2010
	Housing	Housing costs	Percent of households with housing costs >= 30% of household income	27%	31%	--	CHR, ACS 2007-2011
			Median value of owner-occupied housing units	\$112,000	\$137,000	--	US Census Bureau, ACS 5 yr est. (2007-2011)
	Social Support	Inadequate social support	Percent of adults without social/emotional support (2.5% weight in health factors)	22%	22%	14%	CHR, BRFSS 2005-2010
	Health Behaviors	Tobacco Use	Smoking	Percent of adults that report smoking >= 100 cigarettes and currently smoking (10% weight in health factors)	22%	21%	13%
Percent of women who smoked during pregnancy				18.5%	11.5%		DHEC, PHSIS 2011
Nutrition & Physical Activity		Overweight & obesity	Percent of adults that report a BMI >= 30 (7.5% weight in health factors)	32%	31%	25%	CHR, NDSS 2009
			Low-income preschool obesity rate	15.3%	11.4%	14%	DHEC, Food Environment Atlas 2009
		Physical activity	Percent of adults aged 20 and over reporting no leisure time physical activity (2.5% weight in health factors)	28%	28%	21%	CHR, NDSS 2009
			Percentage of adults that report doing physical activity or exercise during the past 30 days other than their regular job	73%	73%	--	DHEC, PHSIS 2008-2010

### Source Legend

Acronym	Full-name
ACS	American Community Survey
ARF	Area Resource File
BRFSS	Behavioral Risk Factor Surveillance System
CDC WONDER	Centers for Disease Control and Prevention's Wide-ranging Online Data for Epidemiologic Research mortality data
CHR	County Health Rankings
DAHC	Dartmouth Atlas of Health Care
DHEC CCD	DHEC Coordinated Chronic Disease Fact Sheet (for Kershaw County)
DHEC SCAN	Department of Health and Environmental Control's South Carolina Community Assessment Network
HRSA	Health Resources and Services Administration
LAUS	Local Area Unemployment Statistics
NCES	National Center for Education Statistics
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCHS	National Center for Health Statistics
NDSS	National Diabetes Surveillance System
NVVS	National Vital Statistics System
PHSIS	Public Health Statistics and Information Services
SAHIE	Small Area Health Insurance Estimates
SAIPE	Small Area Income and Poverty Estimates (via Census Bureau)
SCHA	South Carolina Hospital Association
UCR	FBI's Uniform Crime Reports
USDA	United States Department of Agriculture

# **Phase 4: Identifying Strategic Issues**



## **Phase 4: Identify Strategic Issues**

At this phase of the community planning process, participants develop a prioritized list of the most important issues facing the community. Strategic issues reveal what is truly important from the vast amount of information that was gathered in the key assessments. Addressing strategic issues, a community is being proactive in positioning itself for the future, rather than simply reacting to problems.

**Keep in mind the following questions were answered in Phase Three:**

**The Community Health Snapshot answered:**

- What health conditions exist in the community?

**The Community Voices answered:**

- What is important to our community?
- Why do health conditions exist?
- What is the quality of life in the community?
- What assets are available in the community?

**The Forces of Change answered:**

- What forces affect how to take action?

The answers provided from Phase Three will be instrumental in identifying strategic issues. Identifying strategic issues can be compared to pouring the assessment findings into a funnel - what emerges is a distilled mix of issues that demands attention. These strategic issues form the foundation of the community healthy improvement plan.

**Keep in mind the following questions will be answered when completing Phase Four:**

- What will be done to realize the community's vision?
- Who will do it?
- How it will be done?
- How will we know we have made improvements?
- How can we continually improve?

**Table of Organized Participation and Roles within the Identifying Strategic Issues Phase**

Below is a table that depicts the type of participation recommended for Phase Four. It is best to keep in mind that each community will have its own unique structure for its organization.

<b>Identify Strategic Issues</b>			
<b>Core Group</b>	<b>Steering Committee</b>	<b>Sub-committees</b>	<b>Community</b>
<ul style="list-style-type: none"> <li>• Compile and summarize results from three assessments</li> <li>• Plan process to identify strategic issues.</li> <li>• Provide staff support at meeting(s) in which strategic issues are identified.</li> </ul>	<ul style="list-style-type: none"> <li>• Approve general process for identifying strategic issues</li> <li>• Participate (entire committee) in meeting(s) at which strategic issues are identified and analyzed.</li> </ul>	<ul style="list-style-type: none"> <li>• Charge small groups with specific tasks related to identifying strategic issues, if preferred.</li> </ul>	<ul style="list-style-type: none"> <li>• Engage community through the Steering Committee.</li> </ul>

## **Step One: Determine the Method for Completing this Phase**

- 1. How will we present data from all Three Assessments to our local public health system partners and community members? (This may have already occurred in Phase Three.)**
- 2. How will we ensure our local public health system partners and community members can fully comprehend results from the four assessments?**
- 3. How will we facilitate a process to help our local public health system partners and community members identify strategic issues that are informed by all four assessments?**
- 4. How will we prioritize our strategic issues?**
- 5. How will we ensure everyone is aware of our strategic issues?**

## **Step Two: Present Summary of All Four Assessments**

The summary that can be presented can be tailored from the questions used to make the community profile in phase 3. Please see below:

- 1. What are the top concerns from the community based on the Community Voice Assessment?**
- 2. What is the main health issue(s) facing your community based on the Community Health Snapshot Assessment?**
- 3. What are the health indicators and/or gaps in policies that have caught your community's attention?**
- 4. In the Forces of Change Assessment, what are the main factors impacting your community?**

## Step Three: Brainstorm Potential Strategic Issues

Brainstorm themes that emerge from the four assessments and list the specific data points that inform each theme. Brainstorm without prioritizing. Prioritizing will occur later in the process. This worksheet can assist in brainstorming themes.

### Phase 4 Worksheet:

Steps to Success Activities	Leader of Activity	Due Date	Status of Activity
Review the results from Phase 3 assessments and determine strategic issues <ul style="list-style-type: none"> <li>• At least one of the strategic issues should focus on healthy eating, active living, or tobacco free living</li> </ul>			
Determine the potential impact and likelihood of success for each strategic issue			
Complete Strategic Issues Identification Tool			



## **Step Four: Synthesize and Prioritize Strategic Issues**

Strategic issues have significant consequences for the community and the local public health systems. Determining the consequences of not addressing an issue will help the community members determine if the issue will be a priority strategic issue.

To determine when an issue is strategic, ask partners and community members the following questions:

- 1. Is the issue related to our community's vision?**
- 2. Will the issue affect our entire community?**
- 3. Is the issue something that will affect us now and in the future?**
- 4. Will the issue require us to change the way we function?**
- 5. Is there an obvious solution to this issue?**
- 6. In order to address the issue, do we need leadership support?**
- 7. Are there long-term consequences of us not addressing the issue?**
- 8. Does the issue require the involvement of more than one organization?**
- 9. Does the issue create tensions in the community?**

### **Keep in mind:**

The more times you answer *yes* to the questions above the more strategic the issue is.

## Strategic Issues Identification Tool

Strategic issues are the fundamental policy choices facing an organization's or system's vision, mandates, values, services, clients, resources, or operations. Please complete for each strategic issue.

1. Identify the strategic issue. Phrase the issue as a question. (Example: *How can the public health community ensure access to population-based and personal health care?*)
2. Why is this issue? What convergence of external opportunities and threats, system strengths and weaknesses, health status findings or community themes makes this an issue?
3. What is the feasibility of addressing this issue?
4. What is the impact of addressing or not addressing this issue?
5. What are your community's top three prioritized strategic issues to focus on during this first year?

## **Step Four: Synthesize and Prioritize Strategic Issues continued**

There is no one way to prioritize strategic issues. Community members and local public health system partners should identify the criteria and process to prioritize strategic issues. It is best to identify three to five strategic issues. More than five strategic issues may be difficult to manage.

Remember to ensure that the strategic issues resonate with the community members and local public health system partners. Some communities use targeted focus groups to obtain feedback regarding the chosen strategic issues. Be sure to reference the vision when determining strategic issues so that all of your priorities align.

**Resources for Prioritization can be found on the next two pages and there are other examples here: <http://www.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf>**

# NOMINAL GROUP TECHNIQUE WORKSHEET

The following is a useful method for prioritizing strategic issues. This can be used with the Steering Committee.

1. Generate strategic issues based on the data
2. Write the strategic issues on a flip chart, ask for clarifying questions.
3. Each participant ranks the order of the strategic issues

**EXAMPLE:**

- Strategic Issue A: 3
  - Strategic Issue B: 2
  - Strategic Issue C: 4
  - Strategic Issue D: 1
- “4” is the most important ranking and “1” is the least important.

4. **Combine the rankings of all participants.** Add the totals for each strategic issue. The strategic issue with the highest total is the top priority. The strategic issue with the next highest total is the second priority and so on.

**EXAMPLE:**

	Participant 1	Participant 2	Participant 3		TOTAL
Strategic issue A	3	4	4	=	11
Strategic issue B	2	1	2	=	5
Strategic issue C	4	3	3	=	10
Strategic issue D	1	2	1	=	4

Adapted from Michael Brassard, Diane Ritter, Francine Oddo and Janet MacCausland. 2007. *The Public Health Memory Jogger II*. Salem, NH: GOAL/QPC.

## Prioritization Matrix Worksheet

	[Strategic issue 1]	[Strategic issue 2]	[Strategic issue 3]	[Strategic issue 4]	[Strategic issue 5]
<b>Importance</b>					
<b>Control</b>					
<b>Serious</b>					
<b>Size</b>					
<b>Effective Actions</b>					
<b>Total</b>					

**Directions:** Decide in advance how many priority areas you feel you can reasonably handle (this can be a range). Replace the column headings with the name of your strategic issues. Individually rate each issue based on the criteria in each row from 1 (low) to 10 (high). Once completed, break into small groups (~5 people) and come up with an average for each variable within each strategic issue. Report out to the larger group, using the same process as within the smaller group. Once completed, total up the scores for each strategic issue. If there's a tie which would create an additional priority area, discuss with your group about how you want to handle this.

**Note:** When used in Kershaw, importance and control were rated as "high", "medium", or "low". When scoring, "high" was converted to a 3; "medium" to a 2; and "low" to a 1.

Criteria
<b>Importance:</b> How important is this issue to the community?
<b>Control:</b> Is this an issue that can be controlled?
<b>Serious:</b> How serious is this issue according to the data (is it killing people, is it costing a lot of money)?
<b>Size:</b> How many people does this issue impact?
<b>Effective Actions:</b> Are there some effective actions that can take place with this issue?

## **Step Five: Disseminate Results**

Share the three to five strategic issues with everyone who participated in the process and the community at large. When disseminating results, create an opportunity for people new to the process to learn more and get involved in the action cycle. On the next page is a communication plan that will aid in disseminating results.

## **Communications Planning**

In order to grow your organization and/or reach your target audience you must have a clear plan to get your message out. A communications plan can outline the types of communications that will take place and who is responsible for which components. Larger organizations may have one or more people who are devoted to this task. Smaller organizations may rely on volunteers who work on communications along with other duties. In either case planning is essential to maximize effectiveness and accuracy. On the next page, the basic components of a communications plan are discussed. The general order may vary slightly depending on the needs of your organization.





## Community Engagement Toolkit Marketing and Outreach Plan

**Mission** – What is the primary purpose of your group or organization? Are you trying to raise awareness? Do you have a call to action? You must first be clear about what your organization is trying to accomplish (you may have multiple objectives) before you can craft clear communication messages

**Message** - What is the purpose of your communication? Are you trying to educate, raise funds, recruit volunteers or announce an event? What are the key points in the message that you are trying to communicate? Keep the number of points to a minimum so that those you are trying to reach can retain the information. This is true for media interviews and for outreach materials.

**Money** - Define your budget. Do you have any resources - money or otherwise? If you have money where do you want to spend it? How long do you want your message to run? If you do not have a budget do you have a partner (or supportive business or other entity) that is willing to pay for your promotional campaign(some businesses will consider this if you split the advertising space with them. Ex. They purchase a full page ad and half the page goes to them and half the page goes to you?)

**Mankind** - Define your audience. Who are you trying to reach with this particular message? The answer is never everybody. No one message can effectively reach every audience. There is always a certain gender, age, ethnicity, geographic area or population affected by your topic and that makes up your primary audience. You can look back at your mission and those primarily affected by it to help define your audience. It is better to craft several specific messages than to try to reach everyone with one general message.

**Medium** - Define your medium – What type of media do you want to use? You can choose from print, broadcast, internet, billboards, fliers & posters. Your budget and your audience are key factors in which medium you choose. Do not forget to look at smaller, local media outlets to help reach your target audiences. Often your budget will go much farther and you can have more impact. Nontraditional mediums including neighborhood newsletters or church bulletins can provide exposure for your organization.

**Maximize** – Make sure to ask for added value items while you are negotiating your advertising packages. You have more leverage to work in interviews and added mentions while negotiating the paid advertising than after the fact. Have a spokesperson already identified to take advantage of interview opportunities. Have success stories ready. Overlap your ad schedules for maximum impact. Your target audience will feel as if they are hearing or seeing you everywhere and may be more apt to take the time to pay attention to your message.

**Monitor** – Every outreach campaign should be evaluated for effectiveness. Decide in advance how you will measure the success of the campaign. Be sure to build in ways to track where your responses are coming from. A campaign can be done in phases to allow for modifications if the messages are not being well received. If you plan to use surveys, focus groups and other methods of getting direct feedback from members of your target audience be sure to plan for that in your initial budget.

**Maintenance-** A strong outreach campaign must be maintained and updated periodically. Audiences can grow tired of the same images and ad copy. Keep your messaging up to date and make sure that any data used is the most recent available.

What other ways can I promote my subject besides or in addition to buying advertising?

- Word of mouth (WOM)- Be careful with this. Word of mouth can be hard to control and can turn very negative very quickly
- News stories in both print and broadcast media – Think of ways to make your subject newsworthy
- Press releases and press conferences – Give the media a reason to pay attention to your subject or come to your press conference
- Posters, brochures, and fliers – Make sure they are professional with a clear call to action and contact information
- Outreach and presentations to other health and community service providers and to community groups and organizations
- Special events and open houses that your organization holds - Can you partner with an organization or business who can host an event for you?

# **PHASE 5:**

# **Formulating Goals and**

# **Strategies**



**Phase 5: Formulate Goals and Strategies**

During this phase, the community and local public health system partners form goal statements related to each strategic issue and identify strategies for achieving each goal. It’s important to use assessment data to inform goal setting so that your goals are realistic and doable.

Keep in mind the following questions will be answered when completing Phase Five:

- What are the long-term results associated with identified strategic issues?
- What strategies can the community take to reach the goals?

**Table of Organized Participation and Roles within Formulate Goals and Strategies Phase**

Below is a table that depicts the type of participation recommended for Phase Five. It is best to keep in mind that each community will have its own unique structure for organization.

Phase Five: Formulate Goals and Strategies			
Core Group	Steering Committee	Sub-committees	Community
<ul style="list-style-type: none"> <li>• Prepare assessment information to assist in developing strategies and goals.</li> <li>• Plan process to formulate goals and strategies, including identifying and supporting sub-committee(s) if needed.</li> <li>• Plan and staff the meeting(s) where goals and strategies are formulated.</li> <li>• Summarize the results of the meeting(s) results.</li> <li>• Draft the planning report to guide next steps.</li> </ul>	<ul style="list-style-type: none"> <li>• Participate (entire committee) in meeting(s) at which strategies and goals are selected and confirmed.</li> <li>• Oversee development of the planning report and adopt the plan.</li> <li>• Ensure community members input and support of strategic issues.</li> </ul>	<ul style="list-style-type: none"> <li>• May be formed to discuss each strategic issue in-depth and identify the goals, strategies, and barriers.</li> </ul>	<ul style="list-style-type: none"> <li>• Obtain community input to develop realistic and effective strategies.</li> <li>• Obtain broad community support of goals and strategies in some manner.</li> </ul>

## **Step One: Determine How Goals and Strategies Will Be Developed**

**1. Where is the meeting being held and how long will it take? (e.g., one-day retreat, series of meetings?)**

(Hints: Please understand that this process will take time. The methods should be selected by the time and people that are available. Turnover can be a challenge in this process. It is important to be flexible and prepared.)

**2. Who will be involved in developing goals and strategies?**

(Hint: Please refer to the table on the page above for a reference on how to structure the core group)

**3. Who will facilitate the meeting for developing goals and strategies?**

Tips for Facilitator:

- Prepare. Prepare. Prepare. As a facilitator, your job is to make sure that the purpose of the meeting is accomplished.
- It may be a good investment to use resources to hire a consultant
- Distance yourself from the subject. This is time to hear everyone else's voice. If you don't believe you can facilitate without contributing to the input, you may need to choose another facilitator
- Being a facilitator takes time and training (formal or informal). Reach out to others who facilitate for tips and/or resources.
- Facilitators should typically only facilitate, meaning they should not have a position (typically leadership) that may present bias.
- Watch time. Time can get away. Devise methods in which you can keep track of the time to make sure the meetings are productive.
- Having a partner when facilitating is extremely beneficial (taking notes, brainstorming meeting designs, etc.)
- After facilitating, make sure to email the meeting note, group decisions, and handouts used to all members of the group.

**4. How will your group identify and agree upon goals and strategies?**

## **Step Two: Develop Goals**

First, have your vision statement handy. This should have been created in phase two. This is to make sure that the goals and strategies developed in this phase align with the vision statement. Use the Brainstorm Worksheet located on the next page to assist you with developing goals.

## Brainstorming Worksheet

**DIRECTIONS:** Use this worksheet to brainstorm the current situation for each of the chosen strategic issues. This information will help you move forward in thinking about the goals and strategies to develop around each issue for Phase Five. Think broadly about each issue when you are completing the worksheet. Add additional tables as needed.

<b>STRATEGIC ISSUE #1:</b>	
<p>Is any organization or group currently doing work on this issue in our community?</p>	
<p>What resources are currently available to address the issue, if any? Hint: Resources come in many different forms, such as: monetary donation, in-kind donations, volunteers, experts, space or buildings available, community or marketing available, etc.</p>	
<p>Who in the community would support work on this issue? What is their potential level of support? Hint: Support can come in different forms, such as: attend meetings, recruit volunteers, organize events, political support, etc.</p>	
<p>What potential barriers are there to addressing this issue? Consider barriers in the following categories: community, policy/legal, technical, financial, other. In other words, what could stop us from reaching our goals/strategies?</p>	
<p>Develop at least one goal that will help answer this strategic issue...</p>	

Now that you have a goal how will you develop specific strategies for your community. Strategies and goals are different from each other. Examples of questions to help with the development of goals and strategies are below:

<b>In developing goals and strategies, communities answer the following questions:</b>
Goals - What do we want to achieve by addressing this strategic issue?
Strategies - How do we want to achieve it? What action is needed?

The next few pages of the toolkit will include methods that can be used to generate strategies.



# **Determine Root Causes of Health Issues: Using the “5 Whys” worksheet**

Consider using this worksheet to identify strategic issues that represent the root causes of poor health or community conditions.

## **What Are the “5 Whys”?**

The 5 Whys is one way to identify root causes to solve a specific problem. It may also help you determine how different root causes of an issue are related to one another. It should focus on why the problem is occurring rather than who or what organization is to blame. It is a way to solve problems and to consider cause-effect relationships.

## **When Should We Use the “5 Whys”?**

It should be used when a diverse group is working to solve a problem. It is especially useful as part of a process to solve complicated issues where the real cause of the problem is unclear. It should be used to identify the root cause of a problem, which if eliminated, would prevent a problem from reoccurring.

## **How do the “5 Whys” Work?**

The “5 Whys” are a set of questions that help get beyond the surface of a problem and peel away the layers of symptoms in order to identify the root causes of a problem or condition. This is done by asking the question “why?” five times in order to get to the root cause. Sometimes fewer questions identify the root cause and sometimes you may need to ask the question more than five times. The questioning can stop once the group working together on the issue agrees that it’s identified the root cause of a problem.

***Here's how it works:***

*Write down the specific issue. Ensure that the issue is the current condition. This helps the group formalize the problem and ensure that they agree on and focus on the same problem. Use data to describe the issue when possible*

**Example: Problem or Issue:**

**The rate of fruit and vegetable consumption in Happy City has decreased over the past five years.**

*Ask why the problem is occurring. Write the answer below the problem.*

**Example: Why is this problem happening?**

- 1. People don't have equal access to fruits and vegetables in Happy City.**

If the answer provided does not identify the root cause of the problem that you wrote in the first step, ask why the problem is occurring again and write that answer down.

**Example: Why is the problem stated in #1 happening?**

- 2. Some people are located in areas that only have convenience stores within five miles.**

**Example: Why is the problem stated in #2 happening?**

- 3. People are located in underserved areas that don't have a grocery store within five miles.**

Complete the second and third steps until the group agrees that the problem's root cause is identified.

### Step Three: Outline for Action Planning

Please use the Brainstorming Worksheet and your vision statement (from Phase 2) to complete this section. Also, you should have your “5 Whys” results to develop implementation details for your goals. This outline will help with gathering information to determine the details for completing the strategies that will accompany your goal.

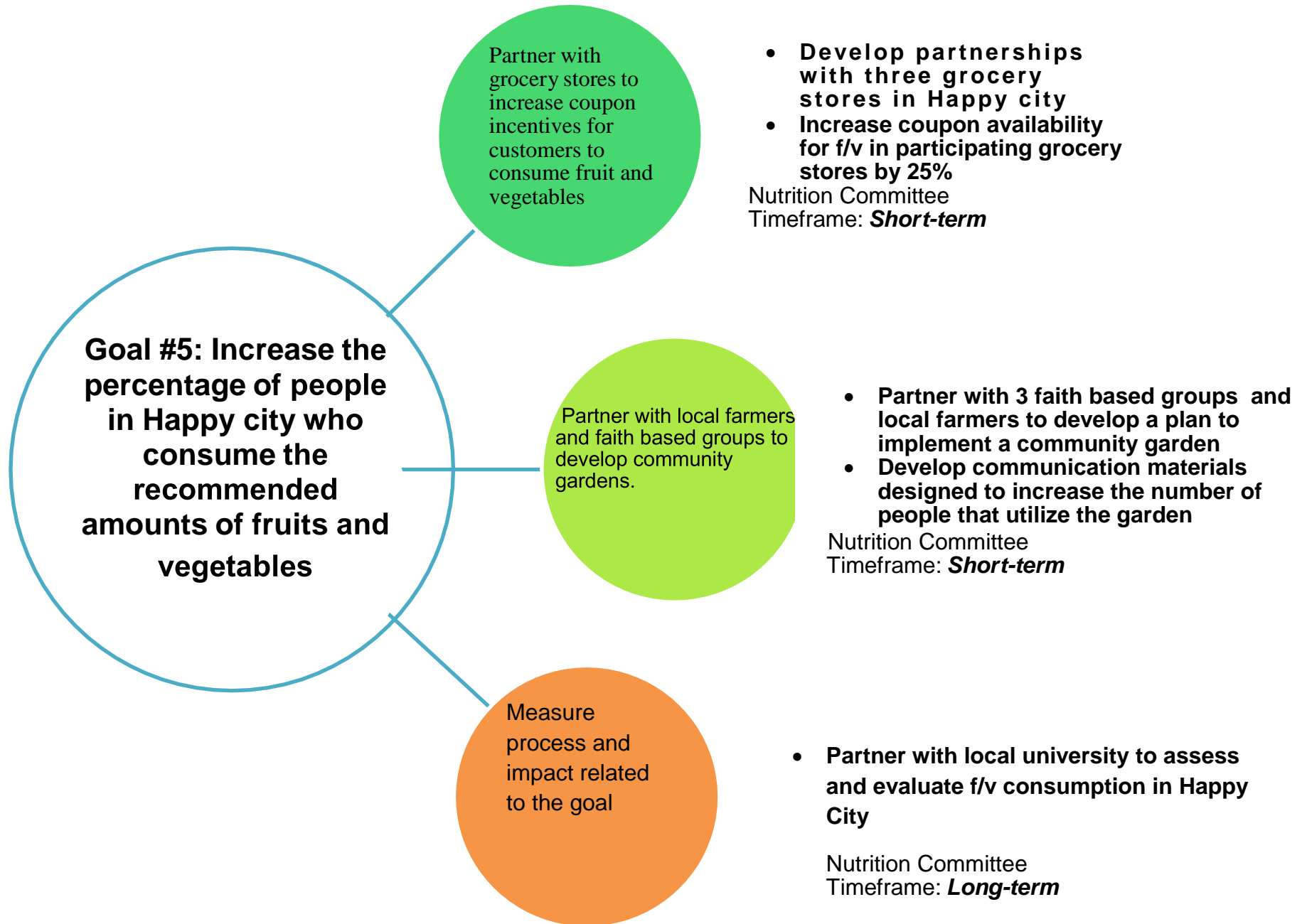
<b>Goal 1:</b>					
	<b>Timeline</b>	<b>Organizations Involved</b>	<b>Resources</b>	<b>Barriers</b>	<b>Implementation</b>
<i>Strategy 1</i>					
<i>Strategy 2</i>					
<i>Strategy 3</i>					

<b>Goal 2:</b>					
	<b>Timeline</b>	<b>Organizations Involved</b>	<b>Resources</b>	<b>Barriers</b>	<b>Implementation</b>
<i>Strategy 1</i>					
<i>Strategy 2</i>					
<i>Strategy 3</i>					

<b>Goal 3:</b>					
	<b>Timeline</b>	<b>Organizations Involved</b>	<b>Resources</b>	<b>Barriers</b>	<b>Implementation</b>
<i>Strategy 1</i>					
<i>Strategy 2</i>					
<i>Strategy 3</i>					

<b>Goal 4:</b>					
	<b>Timeline</b>	<b>Organizations Involved</b>	<b>Resources</b>	<b>Barriers</b>	<b>Implementation</b>
<i>Strategy 1</i>					
<i>Strategy 2</i>					
<i>Strategy 3</i>					

The following graphic is an example of how to display goals and accompanying strategies.



# **PHASE 6: ACTION CYCLE**



## **Phase 6: Action Cycle**

The Action Cycle involves three activities:

- Planning
- Implementation
- Evaluation

Action planning and implementation in this process is very similar to the planning many people conduct on a daily basis. However, in this process, you are orchestrating activities among different individuals and organizations.

The following are valuable to ensuring that the community successfully implements its strategic plan:

- Transparency
- Effective Communication
- Trust
- Leadership.

In this phase, you will use goals and strategies identified in the previous phase to develop a community health improvement plan. Your subcommittee will implement the work plans and evaluate how well they are meeting goals and objectives. Based on evaluations work plans will be revised as appropriate.

The commitment and engagement you have cultivated and the evaluations and improvements you have made throughout the process are strong foundations for collective action. Successful processes ensure all people involved know what actions are being taken by whom and how those actions relate to the ultimate vision.

Most committees create subcommittees to address one strategic issue or one goal. The subcommittees develop measurable objectives and identify activities related to their assigned topic. Subcommittee can use the implementation worksheet on the next page to identify who will do what by when. This worksheet shows how actions are related to strategic issues and how the community will know whether the activities meet objectives. Subcommittees can be made up of people who have and have not participated in the process. It is important to engage new participants in this process though.

Keep in mind the following questions will be answered when completing Phase Six:

- What will be done to realize the community's vision?
- Who will do it?

- How will be done?
- How will we know we have made improvements?
- How can we continually improve?

**Table of Organized Participation and Roles within the Action Cycle Phase**

Below is a table that depicts the type of participation recommended for Phase Six. It is best to keep in mind that each community will have its own unique structure for each organization.

<b>Phase Six: Action Cycle</b>			
<b>Core Group</b>	<b>Steering Committee</b>	<b>Sub-committees</b>	<b>Community</b>
<ul style="list-style-type: none"> <li>• Provide support to assure that action occurs and that those actions are sustainable</li> <li>• Recruit additional participants for planning, implementation, and evaluation as needed.</li> <li>• Support sub-committees and Steering Committee as needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Oversee action planning, implementation, and evaluation across all strategies.</li> <li>• Oversee recruitment of additional participants to assist in planning, implementation, and evaluation as needed.</li> <li>• Secure and/or assist in ensuring Resources needed for planning, implementation and evaluation are available.</li> </ul>	<ul style="list-style-type: none"> <li>• Sub-committee(s) plan, implement, and evaluate work plans</li> <li>• Sub-committees execute action plans for each strategy and report back to Steering Committee as requested.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure community is aware of actions and progress.</li> <li>• Engage community members in implementation to increase likelihood of success.</li> </ul>

## **Step One: Organize for Action**

**1. Are the right people included?**

(Hint: Given these strategic issues and priorities that were identified is there appropriate representation for the health issues at hand. For example, tobacco was identified as a priority, are there any people at the table that represent this particular issue?)

**2. Who or what organization is missing?**

**3. What sub-committees should be convened?**

(Hint: Roles and responsibilities should be reviewed)

**4. How will we ensure accountability for planning, implementation, and evaluation of the action plans?**

(Hints: Core group revisits action plans, task lists, and meeting minutes)



## Step Two: Develop Objectives

Each sub-committee should be associated with a strategic issue, goal, or strategy. Sub-committee members should work together to write specific, measurable, achievable, realistic, and time specific (SMART) objectives.

### SMART Objectives list

**OBJECTIVES:** Describe results to be achieved and the manner in which results will be achieved. *Well-written objectives help set priorities and targets for progress and accountability.*

	Yes	No
1. Is the objective <b>SMART</b> ?		
<input type="checkbox"/> <b>Specific:</b> <i>Who?</i> (Target Population) and <i>What?</i> (Action/Activity)		
<input type="checkbox"/> <b>Measurable:</b> <i>How much</i> change is expected?		
<input type="checkbox"/> <b>Attainable:</b> Can be realistically accomplished given current resources and constraints.		
<input type="checkbox"/> <b>Relevant:</b> Addresses needs and proposes reasonable action steps to lead to desirable results.		
<input type="checkbox"/> <b>Time-phased:</b> Provides a timeline indicating <i>by when</i> the objective will be met.		
2. Does it relate to a single result?		
3. Is it clearly written?		

#### Examples:

**Objective 1:** At least 50% of ABC district schools will adopt nutrition standards for food served as outlined in the State’s Department of Education Model School Wellness Policy.

This objective is not **SMART** because it is not **time-phased**. It can be made **SMART** by indicating by when schools will adopt nutrition standards.

**SMART Objective 1:** At least 50% of ABC district schools will adopt nutrition standards for food served as outlined in the State’s Department of Education Model School Wellness Policy by June 1, 2009.

**Objective 2:** By May 15, 2009, students will be moderately to vigorously active at least 50 percent of the time.

This objective is not **SMART** because it is not **specific**. It can be made **SMART** by indicating when/where students will be expected to be moderately to vigorously active.

**SMART Objective 2:** By May 15, 2009, students will be moderately to vigorously active at least 50 percent of the time in all physical education classes.

## SMART Objective Template:

By \_\_\_/\_\_\_/\_\_\_, \_\_\_\_\_ will  
[WHEN-Time phased] [WHO/WHAT-Specific, NUMBER-Measurable]

---

[HOW, WHY (remember to specify results)]

### Tips for Writing SMART Outcome Objectives

- Objectives should be written in SMART (specific, measurable, achievable, realistic, and time specific) format.
- Quantitative **baselines** should be provided for each objective that leads to an increase, decrease, or maintenance over time. Even if you do not provide a quantitative baseline, if the SMART goals indicate an increase, decrease, or maintenance, it is important to know the baseline data to set appropriate goals. For example, “By December 2014, Happy City will increase their fruit and vegetable consumption from 25% of the surveyed population eating five fruits and/or vegetables daily to 50% of the surveyed population eating five fruits and/or vegetables daily.”
- Referencing a logic model makes developing SMART objectives easy. Rephrase outcomes in the logic model into SMART objectives.
- Keep in mind the following question when writing outcome objectives: What is the change that we are looking for?

### **Step Three: Establish Accountability for Achieving Objectives**

Establishing accountability does not mean that one individual or organization has power over other individuals and can use that power to demand that things get done. In this process, you want to create an understanding among your partners and community members that in order to achieve your collective goals and vision, you need to work together.

Collective action requires that people are committed to:

- Process
- Vision
- Goals

Building commitment starts at the beginning of the process with proper engagement. If the process was truly collaborative from the beginning, people will more likely be committed and accountable to implementing plans.

It is essential to provide clear guidance on:

- Roles
- Responsibilities
- Expectations

Keep in mind that it is important to check-in periodically with people assigned with tasks to see what challenges they are facing and what can be done to overcome those challenges. It is important to remember that this will be a fluid, flexible document. It is important to understand that the plan can be reassessed or changed according to the community's needs.

## **Step Four: Develop Action Plans**

Keep in mind the questions you answered in the preceding steps as you go through the “90-180 Day Implementation Worksheet.” The worksheet can be added to and replicated as needed when creating work plans.

The “90-180 Day Implementation Worksheet” has been developed by the Institute of Cultural Affairs and is one element of the Technology of Participation (ToP) facilitation methodology.

## Implementation Worksheet Example

<b>Strategic Issue:</b>		<b>Why:</b>	
<b>Objective(What):</b>		<b>Start Date:</b>	
		<b>End Date:</b>	
<b>Implementation Steps (How):</b>	<b>When:</b>	<b>Who:</b>	<b>Evaluation Measures</b>
1.			
2.			
3.			
4.			
5.			
6.			
<b>Team Members:</b>	<b>Collaborators or Partners:</b>	<b>Special Considerations:</b>	

## Implementation Worksheet Example

<b>Strategic Issue:</b> List the name of the strategic issue that this work is addressing.		<b>Why:</b> Write a brief sentence explaining the strategic advantage of moving in this direction. How will this work affect the strategic issue?	
<b>Objective (What):</b> List the specific desired accomplishment in past tense, as if it had already happened—for example, created an inventory of existing resources.		<b>Start Date:</b> <b>End Date:</b>	
<b>Implementation Steps (How):</b> List the steps to complete this accomplishment. Start each step with a verb that captures the action. Make it as concrete as possible.	<b>When:</b> Identify the completion date of each step.	<b>Who:</b> Identify who will complete the step.	<b>Evaluation Measures:</b> Write down “measures” you will use to evaluate the degree of success that you have accomplished completing each step
1.			
2.			
3.			
4.			
5.			
<b>Team Members:</b> List the names of all the team members	<b>Collaborators or Partners:</b>	<b>Special Considerations:</b>	
	Build a list of potential collaborators who should be involved because they can help this effort or because they need to be engaged for the overall success of the plan.	List any special considerations such as: <ul style="list-style-type: none"> <li>• Resources needed;</li> <li>• Seasonal time considerations;</li> <li>• Staff/ people time required; and/or</li> </ul> Others.	

### **Step Five: Review Action Plans for Opportunities to Coordinate**

The Steering Committee should review implementation worksheets from the different sub-committees to determine if there are opportunities to streamline efforts. Feedback from the Steering Committee should inform revisions to implementation plans

Hint: One person from the steering committee should be on each of the sub-committees to act as a liaison to the leadership. This will help coordinate efforts.

## **Step Six: Take Action**

Sub-committees should use the implementation worksheet to guide action. As your sub-committee implements its plans, it is important to monitor progress and collect data to ensure actions are achieving measurable objectives and community goals. It is vital that the sub-committee and the steering committee are documenting their progress during their meetings.

The process up to this point prepares communities to take action. It is important that you celebrate success and share your accomplishments with your community. During Phase Six, communities implement the work that ideally improves local public health.



## Writing a Community Health Improvement Plan

A community health improvement plan includes a description of your community's process and a summary of the strategic issues, goals, strategies, and activities. A community health improvement plan is a long-term, effort to address public health issues. These issues are determined based on the results of community health assessment activities. A community health improvement plan is a community-owned plan. This is not a plan for just one agency, but is representative of the local public health system. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources.

Community health improvement plans can be presented in the following manner:

1. Executive Summary (Example on next page)
  
2. Description of the Process
  - a. Overview of the process;
  - b. Individuals and organizations involved;
  - c. Community vision statement;
  - d. How four assessments were conducted;
  - e. How strategic issues, goals, strategies, and objectives were selected and prioritized.
  
3. Strategic Issues, Goals, Strategies, Objectives, and Activities
  - a. Description of each strategic issue;
  - b. Assessment data related to each strategic issue;
  - c. Goals, strategies, objectives, and activities related to each strategic issue;
  - d. Timeline for achieving the objectives and activities;
  - e. Performance measures and indicators of progress for each activity;
  - f. Individuals and organizations responsible for implementing activities



[eatsmartmovemoresc.org/greenwoodcounty](http://eatsmartmovemoresc.org/greenwoodcounty)  
[facebook.com/eatsmartmovemoregreenwood](https://facebook.com/eatsmartmovemoregreenwood)

## **Community Assessment Executive Summary and Strategic Plan 2013**

**The vision** of Eat Smart Move More Greenwood County is a Greenwood County in which healthy eating and active living are essential to our community where we live, work, learn, pray, and play.

**The mission** of Eat Smart Move More Greenwood is to make the healthy choice the easy choice.

### **Greenwood County Community Profile**

Population:	69,840
	66.2% White (69.1% in SC)
	33.8% African American and other (30.9% in SC)
Uninsured	22% (20% SC)
Children in Poverty	29% (28% for SC)
Children in Single Parent HH	46% (39% for SC)
Teen Births	13.6% (12% for SC)
Low Birth Weight	8.8% (9.9% for SC)
Preterm Births	10.7% (11.5% for SC)
Breastfeeding Initiation	50.3% (61.4% for SC)
Adult Obesity	36.9% (32.4% for SC)
Adult Diabetes	10.4% (10.4% for SC)
Adult Hypertension	35% (33.4%)
Physical Inactivity	31.1% (27% for SC)
Not Meeting Fruit and Vegetable Recommendation	83.9% (82.6% for SC)
Limited Access to Healthy Food	5% (8% for SC)
Adult Smoking	23% (20.5% for SC)

### **Community Voices (from three sources)**

#### ***Self Regional Healthcare Community Assessment Key Informant Interviews and Data Review 2012***

High Impact/High Need:	Access to primary care
High Impact/Medium Need:	Management of diabetes and cardiovascular disease
<b>Medium Impact/High Need:</b>	<b>Rates of obesity, proper nutrition, and physical activity</b>
Medium Impact/Medium Need:	Access to mental health services

#### ***Eat Smart Move More Greenwood County Coalition Agency Partners:***

*Baptist Young Women's Association \* Carolina Health Centers \* City of Greenwood \* Community Initiatives, Inc. \* SCDHEC-Greenwood*

*County \* GLEAMNS \* Greenwood County \* Greenwood County Garden Project \* Greenwood Family YMCA \* Greenwood School District 50 \* Healthy Greenwood Neighborhoods \* Lander University \* The Self Family Foundation \* Safe Routes to School \* Self Regional Healthcare*

### ***ESMM Greenwood Community Survey 2012***

Of 84 respondents, 98% were women, 93% were between the ages of 18 and 34, and 86% were African American.

3.5% had diabetes and 9.5% had hypertension

25% smoked and 13% use smokeless tobacco

Food choices are motivated by availability (13%), price (15%), transportation (8%), and personal preference (56%)

31% exercise 2 days per week and 26% exercise 3 days per week

Main barrier to exercise is lack of time (73%)

### ***Greenwood County Parks and Recreation Master Plan Survey***

Members of the community were asked to evaluate the need for potential parks and recreation facilities. There were 600 respondents who ranked the following as the top 3 needs.

Walking/biking trails, 85.6% rated as needed or strongly needed

Playgrounds, 80.5% rated as needed or strongly needed

Green space and nature preserves, 77.1 % rated as needed or strongly needed

### **Community Health Snapshot (two local sources, compiled from numerous data sources)**

#### ***Self Regional Health Care Assessment 2012***

Key findings in addition to data in the community profile section include:

Greenwood County is projected to have a 2.82% growth in population in the next five years.

There is an anticipated growth of 11.3% in the senior population over age 65 years in the next five years

We rank 16<sup>th</sup> in the state for premature death (years of potential life lost before age 75)

17% have poor to fair health (16% for SC)

Of the population who has low access to a grocery store, 26.6% are kids 0-17 and 14.6% are seniors over the age of 65

Top positive indicators include a moderately high % of women receiving pap smears and very low particulate matter days (air quality)

Top negative indicators include need for internal medicine physicians, very high colon cancer incidence rate, very high breast cancer death rate, and a moderately high colorectal cancer death rate.

### **Local Policy and Environment Review 2013**

Eat Smart Move More Greenwood members gathered information on local policies and environments to support healthy eating, active living, and limiting exposure to second hand smoke.

- Strengths: 18 community gardens with 6 more planned (Update: 22 gardens as of June 2013)  
 Lander University, Piedmont Technical College, and SRHC have smoke free campuses  
 Complete Streets resolutions passed in Greenwood and Ninety Six
- Opportunities: No schools currently participate in Farm to School  
 One of three school districts (District 51) has adopted a model tobacco policy

### **Forces of Change 2013**

Twelve community members from local agencies, neighborhoods, and government met to discuss and identify forces of change for Greenwood County as it relates to health and quality of life. Threats and opportunities listed which can be addressed locally include

#### **Threats**

- Excessive screen time by children and adults
- Lack of community walkability
- Cultural values toward healthy lifestyles
- Personal values and priorities
- Lack of knowledge of chronic disease prevention

#### **Opportunities**

- Educate families and children on healthy eating, active living, and tobacco risk
- Improve quality of family time by increasing healthy options in social, church, school, and work settings
- Apply Complete Streets concepts
- Increase number of and access to neighborhood parks
- Promote local farm products

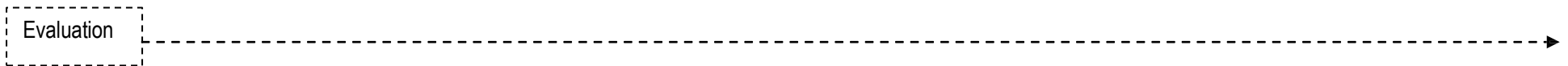
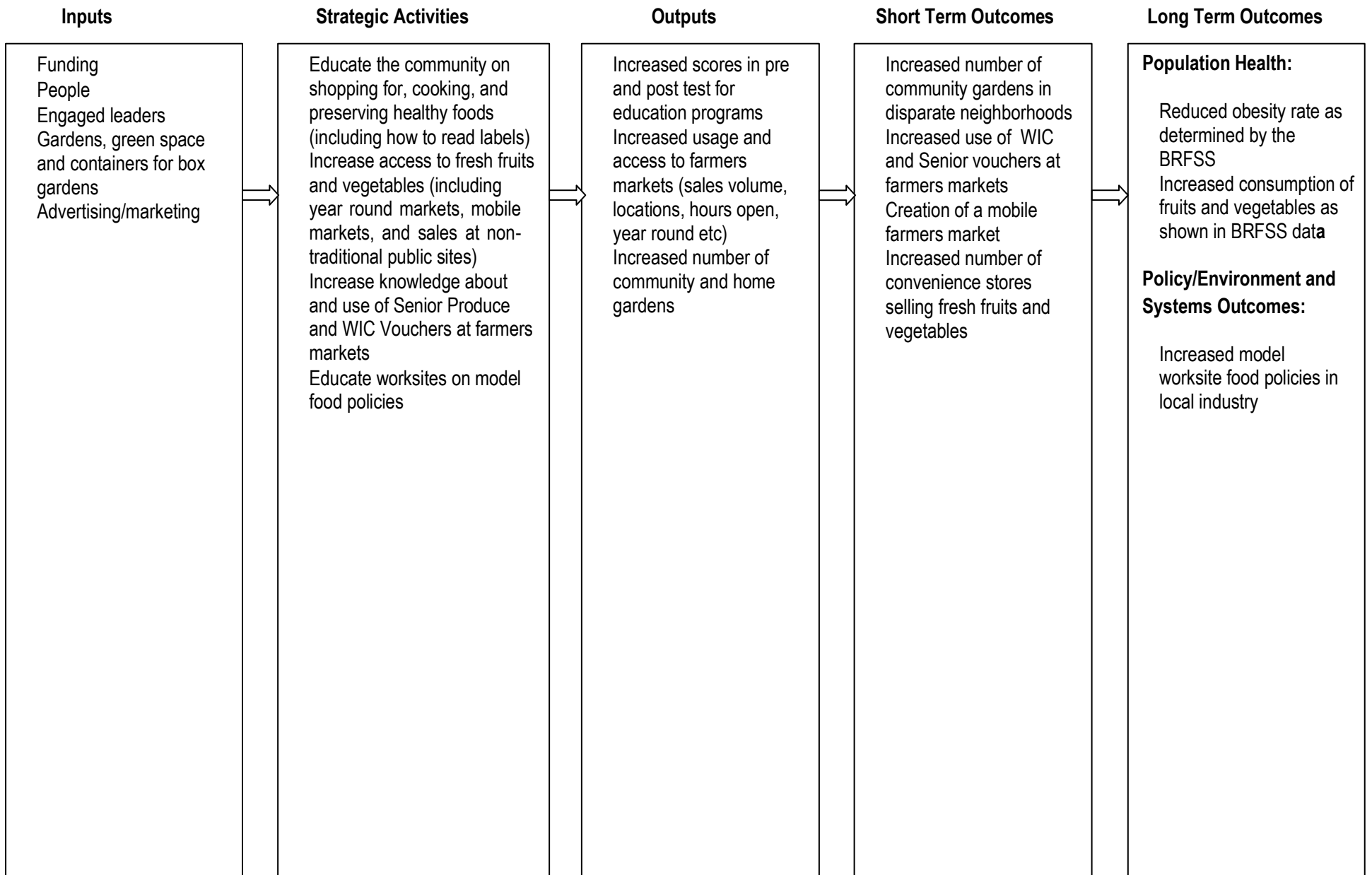
### **Strategic Issues Assessment 2013**

Key strategic issues/strategies were identified by community members that participated in the forces of change assessment. The key strategic issues/themes that emerged from this assessment component include

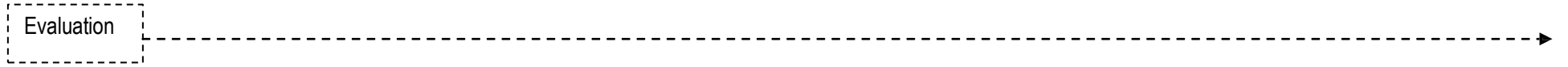
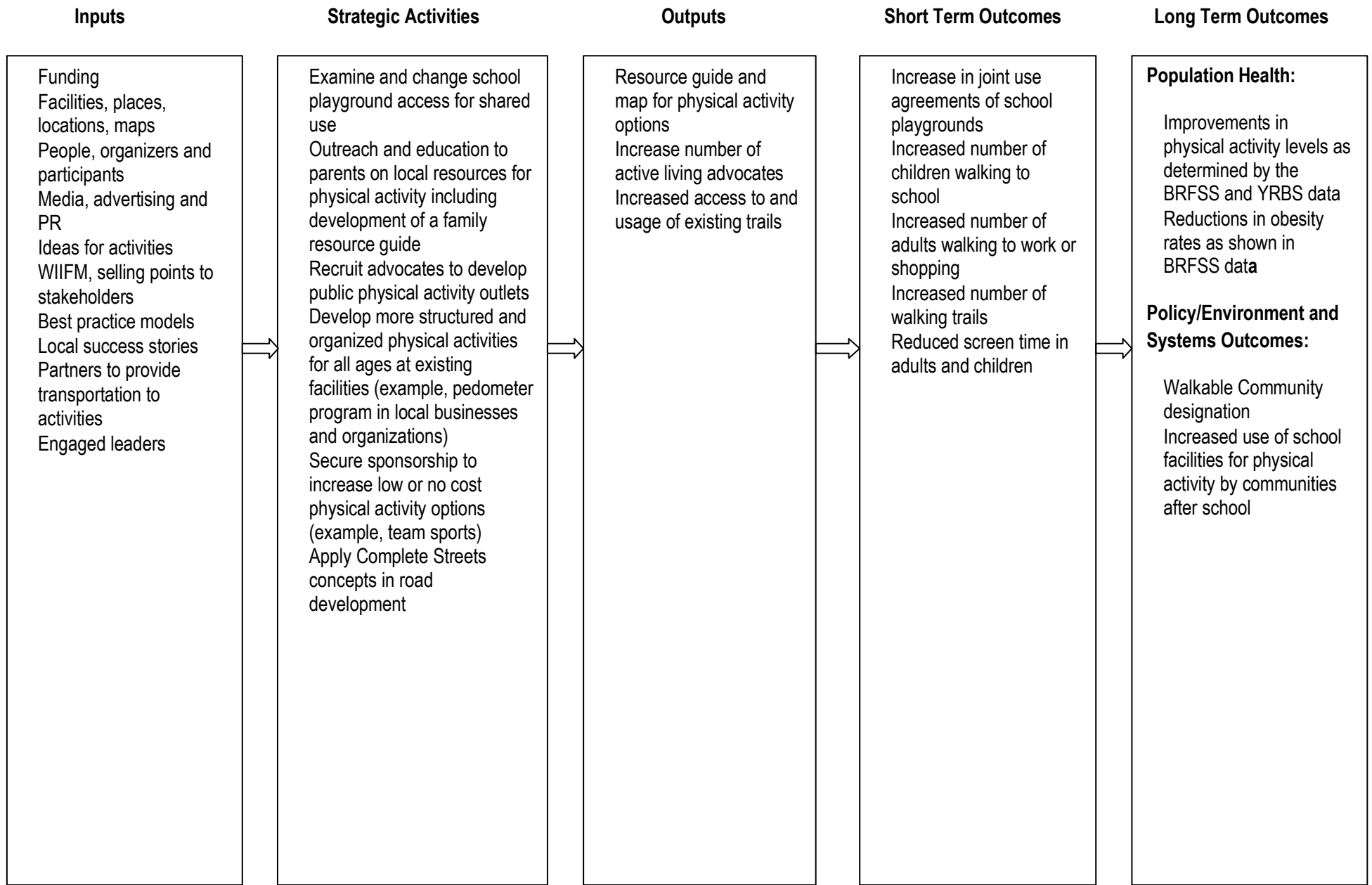
- Access to fresh fruits and vegetables for everyone
- Knowledge of what is healthy eating and how to cook healthy foods
- Access to safe bike and pedestrian routes on streets and trails
- Opportunities for structured and unstructured physical activity
- Reducing exposure to second hand smoke

Coalition and community members also worked on a five year strategic plan for health eating, active living, and reducing exposure to second hand smoke.

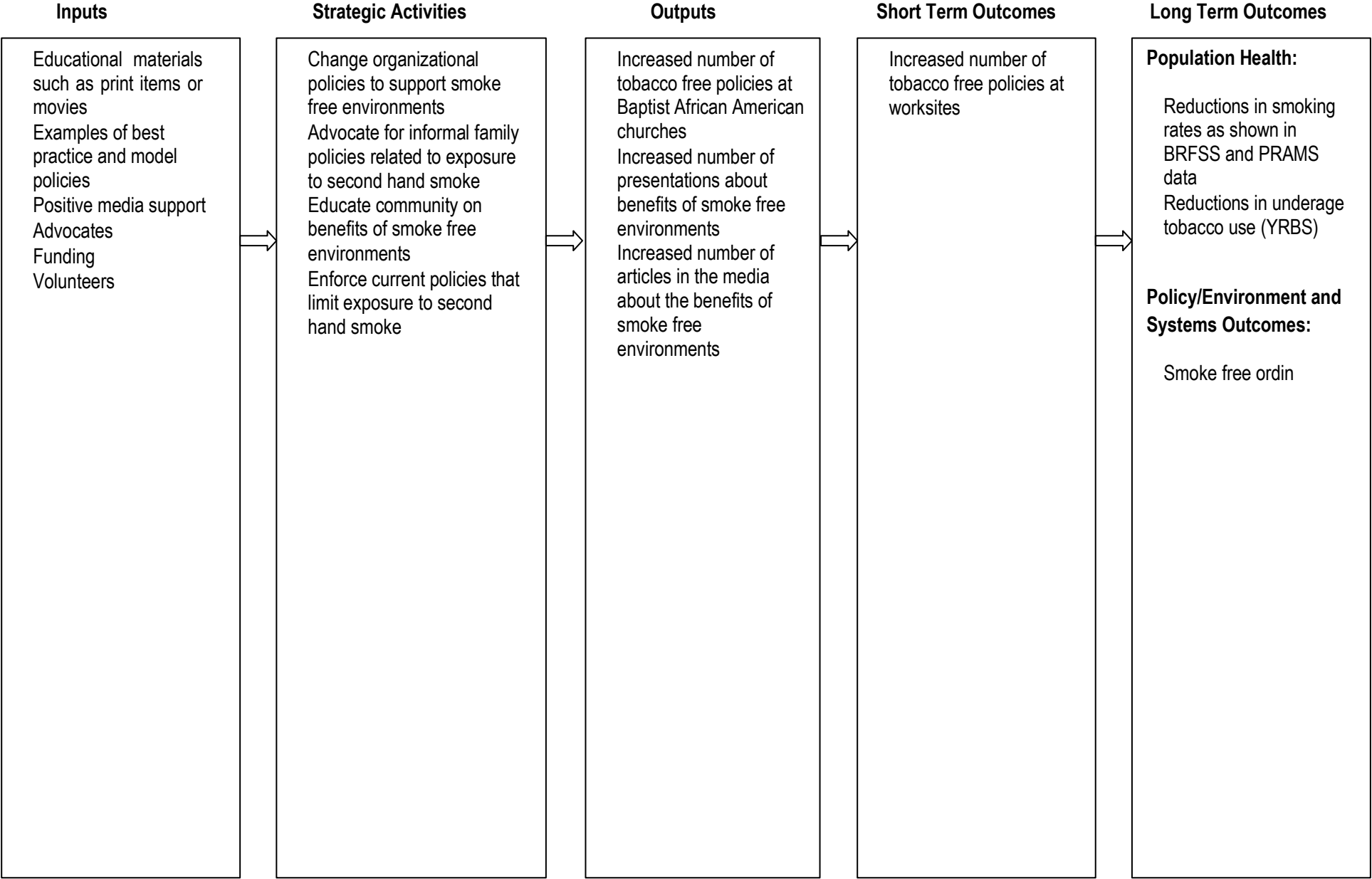
## Healthy Eating Strategic Plan for Greenwood County May 2013



## Active Living Strategic Plan for ESMM Greenwood County May 2013



**Reducing Exposure to Second Hand Smoke  
Strategic Plan for Greenwood County May 2013**







## **Closing**

The Community Assessment process helps communities in developing their own unique path to a successful, healthy community. The Healthy South Carolina Initiative Community Engagement Toolkit is an effective way to get partners engaged in the process. It is also a reflection of all the important phases needed to assess your community's distinct needs. This toolkit assists communities in using the assessment data to prioritize project goals and to support funding requests. By using the HSCI Community Engagement Toolkit, your community is on the right path to achieving its community vision.

# Resources

1. National Association of County & City Health Officials (NACCHO). (n.d.). Example timeline for the MAPP process. [Supplemental material -Word Document]. Retrieved from <http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/phase1.cfm>.
2. National Association of County & City Health Officials (NACCHO). (n.d.). Forces of Change Brainstorming Worksheet. [Supplemental material -Word Document]. Retrieved from <http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/phase3FOC.cfm>
3. National Association of County & City Health Officials (NACCHO). (n.d.). Forces of Change Threats and Opportunities Worksheet. [Supplemental material -Word Document]. Retrieved from <http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/phase3FOC.cfm>
4. National Association of County & City Health Officials (NACCHO). (n.d.). Readiness Assessment Worksheet. [Supplemental material -pdf]. Retrieved from [http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/readiness\\_assessment.pdf](http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/readiness_assessment.pdf)
5. National Association of County & City Health Officials (NACCHO). (n.d.). Strategic

Issues Identification Worksheet. [Supplemental material -Word Document].

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<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/phase4.cfm>

6. National Association of County & City Health Officials (NACCHO). (n.d.). Tip Sheet-

**Guidance for Participant Identification. [Supplemental material -pdf].**

**Retrieved from**

<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Tip-Sheet-Participant-Identification.pdf>



# **Toolkit Supplemental Guide**

*June 2014*

## **Purpose**

The Supplemental Guide for the Toolkit provides resources to coordinators throughout the state of South Carolina. These resources consist of community examples and templates that can be used to help guide the Mobilizing for Action through Planning and Partnership process. Many of these resources were gathered from coordinators throughout the state and can have been identified as “ideal” examples that can be used within your communities. The resources listed in this guide have been identified and placed in their corresponding MAPP Phase.

## **Acknowledgements**

The Community Assessment team would like to thank everyone that contributed to the development of this toolkit.

### **Department of Health and Environmental Control**

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Columbia, SC 29201

### **Office of Public Health Practice**

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Columbia, SC 29208

Materials have been modified and adapted from the following website:

National Association of County and City Health Officials (NACCHO)

<http://www.naccho.org/topics/infrastructure/mapp/>

# Table of Contents

**Phase Overview** **pg. 5**

**Phase 3: Three Key Assessments** **pg. 6**

*Supplemental materials for this phase:*

- *Kershaw County Health Scorecard*
  - ❖ This is a brief overview of the health issues that are occurring in Kershaw County and input from community members about these issues.
- *Kershaw County Indicator Inventory*
  - ❖ The indicator inventory is a tracking device used to organize and potentially monitor health indicators of interest to your community as it pertains to both outcomes and measures.
- *Novant Health Gaffney Medical Center Health Priorities Focus Group*
  - ❖ This document is an example of a focus group that was conducted in the Upstate Region of SC to help supplement the community health needs assessment.

**Phase 4: Identifying Strategic Issues** **pg. 33**

*Supplemental materials for this phase*

- *Fishbone Diagram*
  - ❖ Fishbone diagrams allow individuals and teams to identify, explore, and display all possible root causes related to a problem or condition. There is an example provided for assistance.
- *NAACHO Prioritization Process*
  - ❖ This document details prioritization as a key step in a community health improvement process that serves as a natural transition from focusing on the findings of the community health assessment (CHA) to developing a community health improvement plan (CHIP). Prioritization helps communities focus on key issues in order to maximize impact and use their resources as efficiently as possible.
- *Prioritization Matrix*
  - ❖ This document is another example of how to prioritize issues.

**Phase 5: Formulating Goals and Strategies** **pg. 44**

*Supplemental materials for this phase*

- *Eat Smart Move More Greenwood County Executive Summary*
  - ❖ This is an example of an executive summary for Greenwood County that includes the community health needs assessment data and logic model.

## **Phase 6: The Action Cycle**

**pg. 55**

### *Supplemental materials for this phase*

- *Graphic Display of Strategies from Eat Smart Move More Happy City*
  - ❖ This is a graphic example of how to display strategic issues.

## **Other Resources**

**pg. 57**

- *What is a Gallery Walk?*
  - ❖ This is a collaborative brainstorming and discussion method that moves small groups of people from station to station on a rotating basis as a way to gather and record input.
- *Bike and Pedestrian Task Force Handle Bar Assessment*
  - ❖ This is an example of a bike and pedestrian task force handle bar assessment. This assessment reviewed the built environment around Winthrop University and Downtown Rock Hill.

# Overview of Phases

## **Phase 1: Organize for Success/Partnership Development**

This phase identifies who should be involved in the process and how the partnership will approach and organize the process.

## **Phase 2: Visioning**

This is a collaborative and creative approach that leads to a shared community vision and common values.

## **Phase 3: Three Key Assessments**

The assessments inform the entire process. The assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods. The use of different types of assessment is a unique feature of this process. Most planning processes look only at quantitative statistics and anecdotal data. This process provides tools to help communities analyze health issues through multiple lenses.

## **Phase 4: Identifying Strategic Issues**

This phase uses the information gathered from the assessments to determine the strategic issues a community must address in order to reach its vision.

## **Phase 5: Formulating Goals and Strategies**

This phase involves specifying goals for each of the strategic issues identified in the previous phase. Many communities create a community health improvement plan at the end of this phase.

## **Phase 6: The Action Cycle**

The Action Cycle includes planning, implementation, and evaluation of a community's strategic plan.



# **Phase 3: Three Key Assessments**



Kershaw County Health Scorecard

## KERSHAW COUNTY

Historically, the health of a community was influenced by transition and technology. Presently, community health is influenced by various social, environmental and personal factors. In order to capture the influential factors of health, the public health department uses data to quantify health. This county specific scorecard is intended to provide information for our local health department staff, community agencies/organizations, policy makers and others interested in the improving health status of our citizens.

The Kershaw Community is committed to improving the health of our residents. By focusing on health outcomes, our county residents will benefit with the prevention of unnecessary suffering and the reduced costs of preventable diseases and injuries. Such benefits provide an integral part in creating and sustaining a healthy community.

## DEMOGRAPHIC DATA (2011)

**Table 1: Demographics**

<b>Population – 62,270</b>		
<b>Race</b>	<b>Black- 27%</b>	<b>White- 73%</b>
<b>Sex</b>	<b>Male- 49%</b>	<b>Female-51%</b>
<b>Percent by Age</b>	<b>County:</b>	<b>State:</b>
<b>&lt; 18</b>	<b>24%</b>	<b>23%</b>
<b>18-44</b>	<b>32%</b>	<b>36%</b>
<b>45-64</b>	<b>29%</b>	<b>27%</b>
<b>65-84</b>	<b>13%</b>	<b>12%</b>
<b>85+</b>	<b>2%</b>	<b>2%</b>
<b>Percent below Poverty</b>	<b>15.8%</b>	
<b>Median Household Income</b>	<b>\$43,509</b>	

### LEADING CAUSES OF DEATH (2011)

1. Cancer (151 deaths)
2. Heart Disease (108 deaths)
3. Accidents – (34 deaths)
4. Cerebrovascular Disease

(31 deaths)

5. Chronic lower respiratory disease– (31 deaths)

## HOSPITAL DISCHARGE (2011)

Table 2 represents the top five 2011 hospital inpatient discharges and charges for Kershaw County residents. There were a total of 4,527 patient discharges with 558 (12.3%) classified as ambulatory care sensitive conditions (ACSC).

**Table 2: 2011 Hospital Inpatient Discharges and Charges**

Inpatient		
	Discharges	Charges
Diabetes	99	\$2,064,188
Bacterial pneumonia	95	\$2,451,099
Asthma	66	\$1,131,871
Congestive heart failure	64	\$2,362,436
Chronic obstructive pulmonary disease	63	\$1,358,468
This table only represents all payer sources for adults age 19-64.		
Source: Office of Research and Statistics (ORS)		

Table 3 represents the top five 2011 hospital emergency department discharges and charges for Kershaw County residents. There were a total of 16,146 emergency department discharges with 2,611 (16.2%) classified as ACSC.

**Table 3: 2011 Hospital Emergency Department Discharges and Charges**

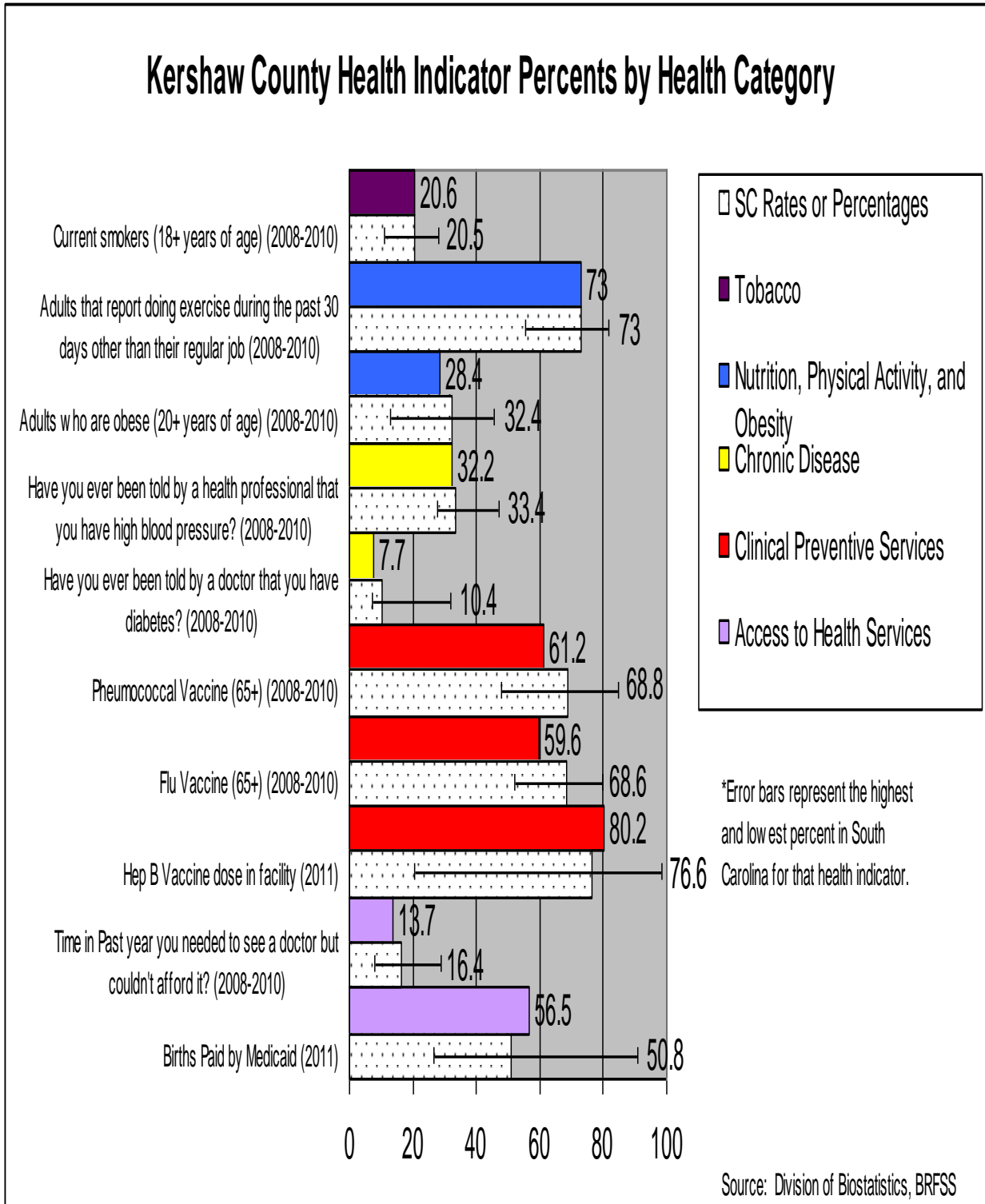
Emergency Department		
	Discharges	Charges
Severe ear, nose, and throat (ENT) infections	523	\$514,068
Kidney/urinary infection	511	\$1,056,677
Dental conditions	361	\$233,353
Asthma	199	\$378,380
Diabetes	164	\$318,330
This table only represents all payer sources for adults age 19-64.		
Source: ORS		

## HEALTH INDICATORS

The three health indicator graphs display the percent/rate of each health indicator by health category. Each health indicator compares the specified county to the South Carolina (SC) percent/rate . The error bars located on each SC percent/rate represents the highest and lowest percent/rate in the state. For example, within Figure 1 the “Current Smokers (18+ years of age) (2008-2010)” health indicator shows the percent of current smokers for Kershaw County was 13% (2008-2010). The percent of current smokers for South Carolina was 20.5% (2008-2010). Comparing the two percents show that the percent of current smokers in Kershaw County (13%) is higher than the state’s percent of current smokers (20.5%). Looking at the error bars, you will see that Kershaw County’s percent of current smokers (13%) graph bar is located closer to the lowest percent of current smokers in the state; this means that, compared to the other 45 counties, Kershaw County does not have the highest or lowest percent of current smokers in the state.

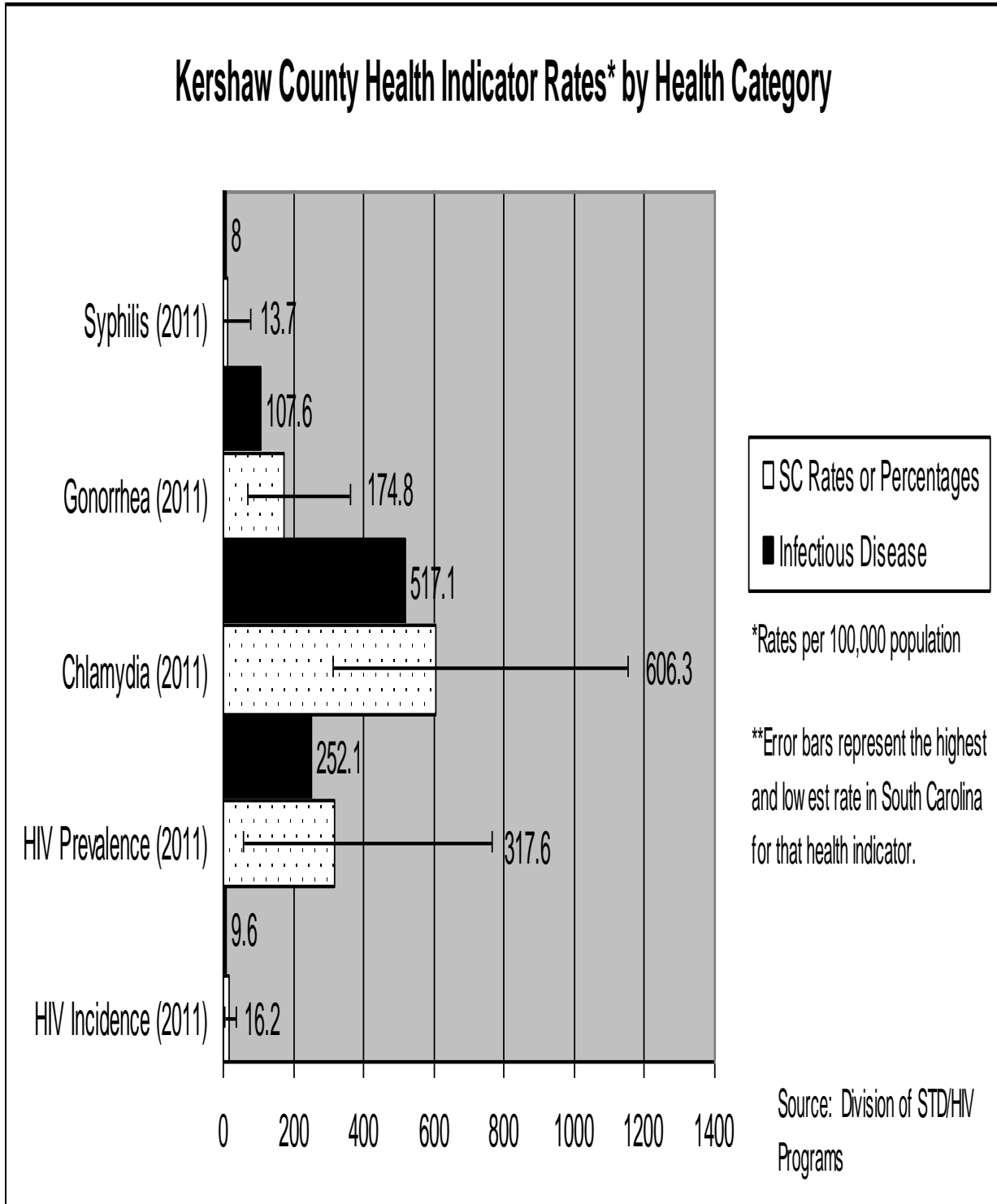
# HEALTH INDICATORS

Figure 1: Health Indicator Graph



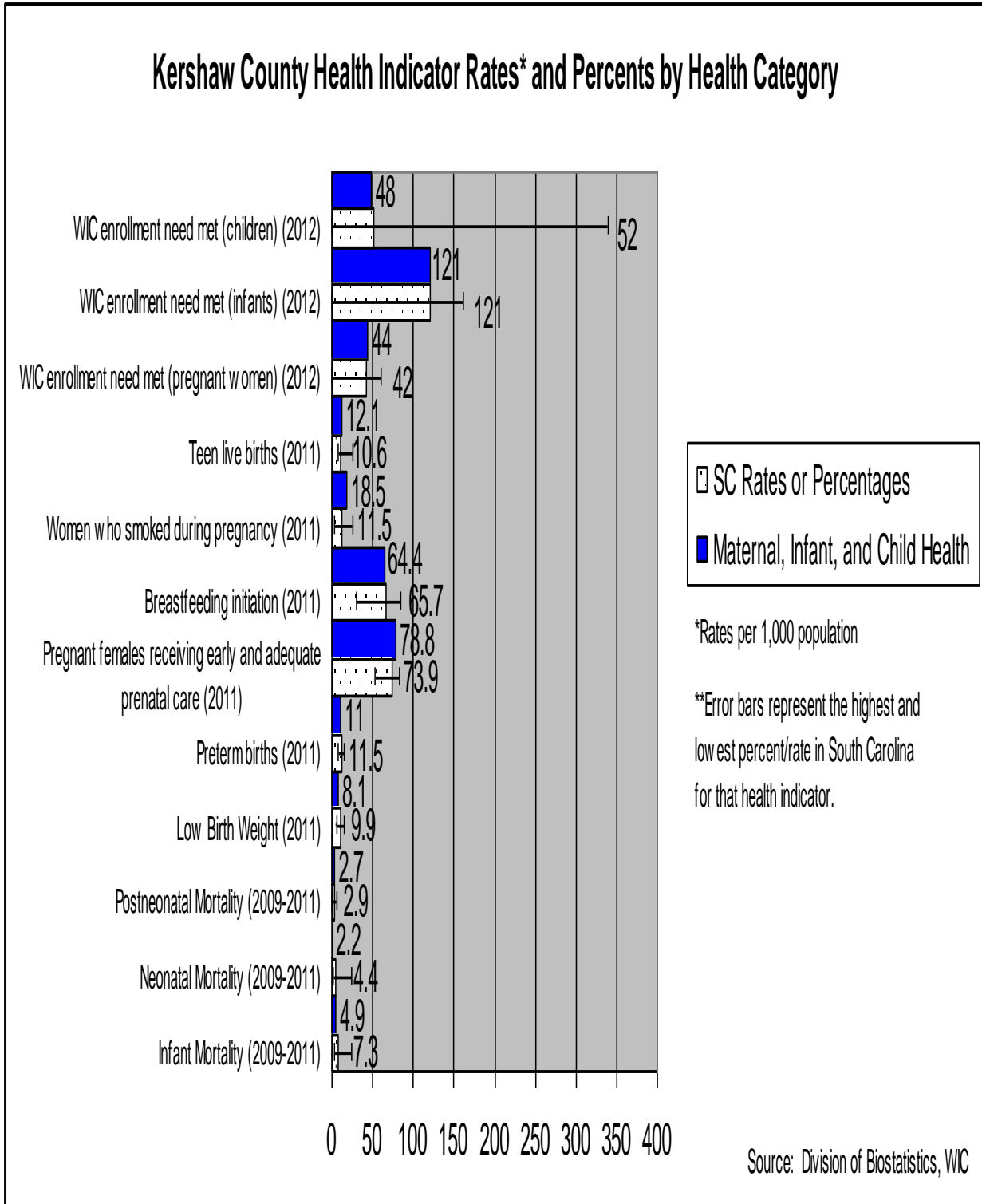
# HEALTH INDICATORS

Figure 2: Health Indicator Graph



# HEALTH INDICATORS

Figure 3: Health Indicator Graph



# COUNTY HEALTH RANKING (2012)

Health Outcomes (How healthy a County is) - Kershaw ranks 10 out of 46 counties

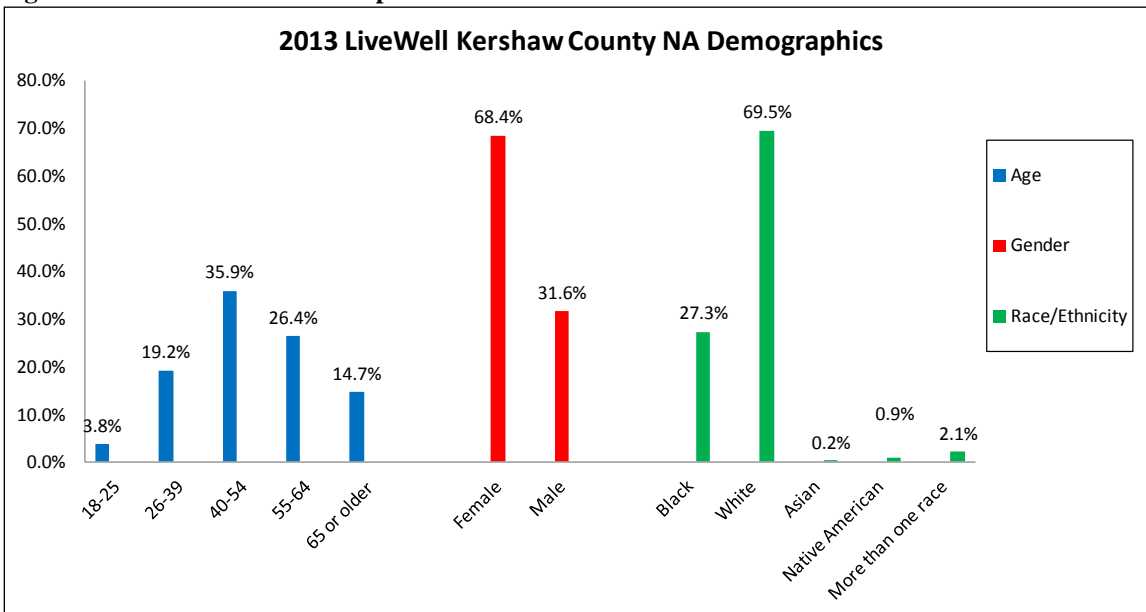
Health Factors (Factors which influence the health of the County) – Kershaw ranks 16 out of 46 counties

Source: County Health Rankings & Roadmaps; Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. <http://www.countyhealthrankings.org/>

## NEEDS ASSESSMENT RESULTS

The data provided in this scorecard was generated using a community survey provided by the HSCI Community Engagement Toolkit to investigate health problems and related community issues in Kershaw county and surrounding areas. The local data set for this scorecard consisted of 920 surveys collected from residents to help us make generalized statements about health issues impacting our community.

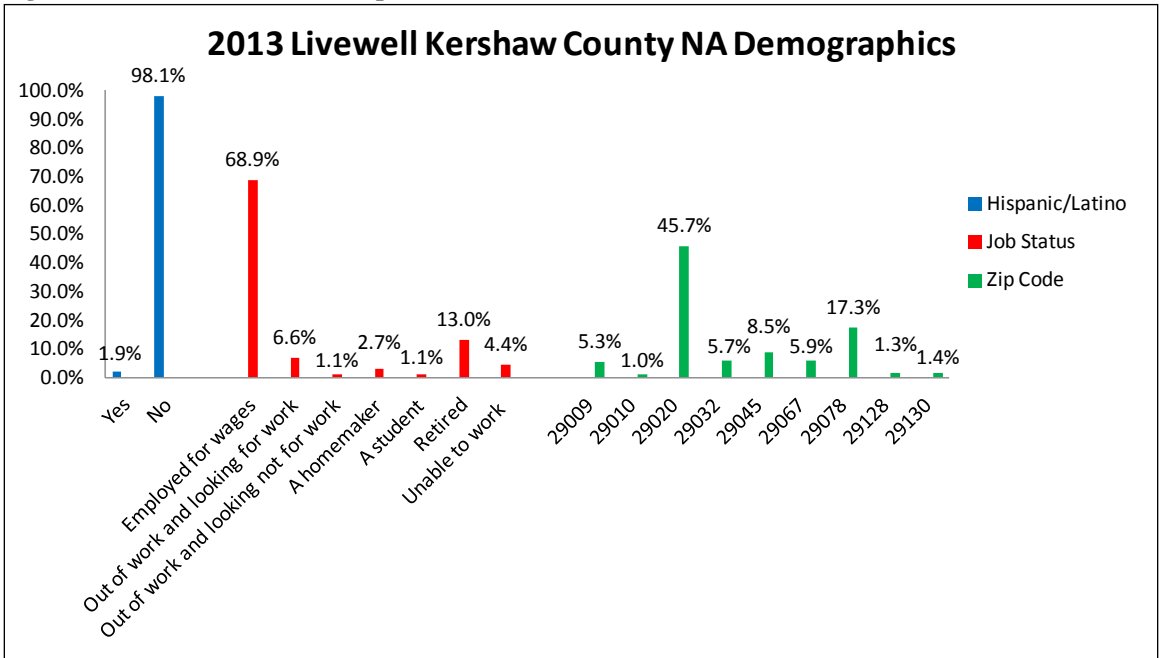
Figure 4: Needs Assessment Graph



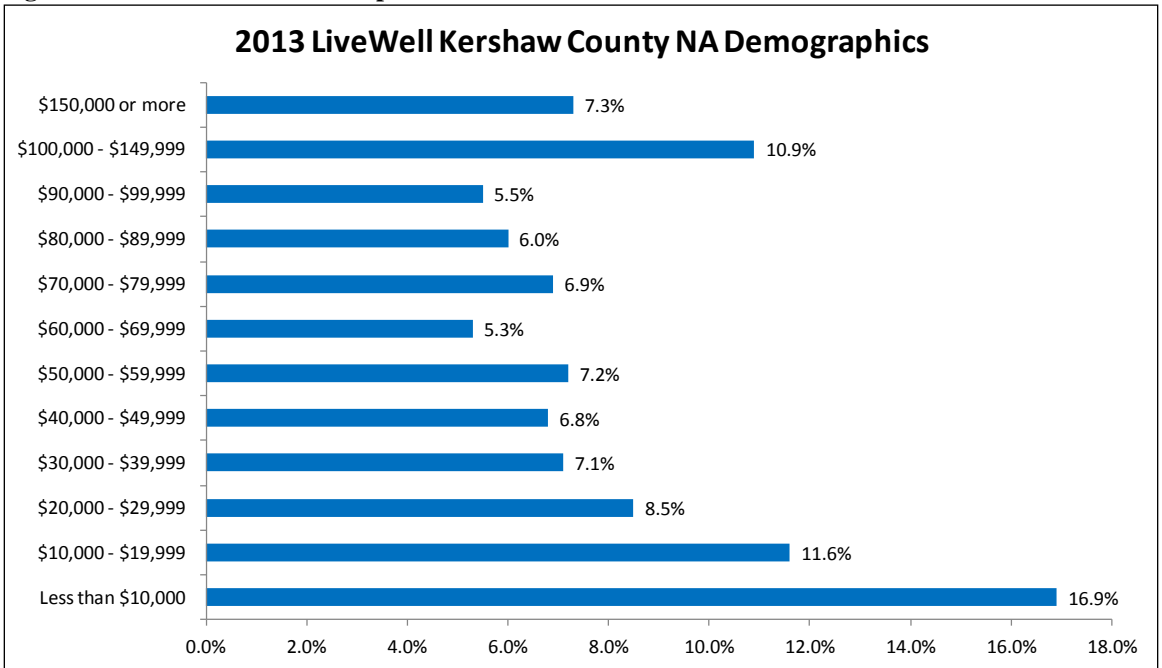


# NEEDS ASSESSMENT RESULTS

**Figure 5: Needs Assessment Graph**

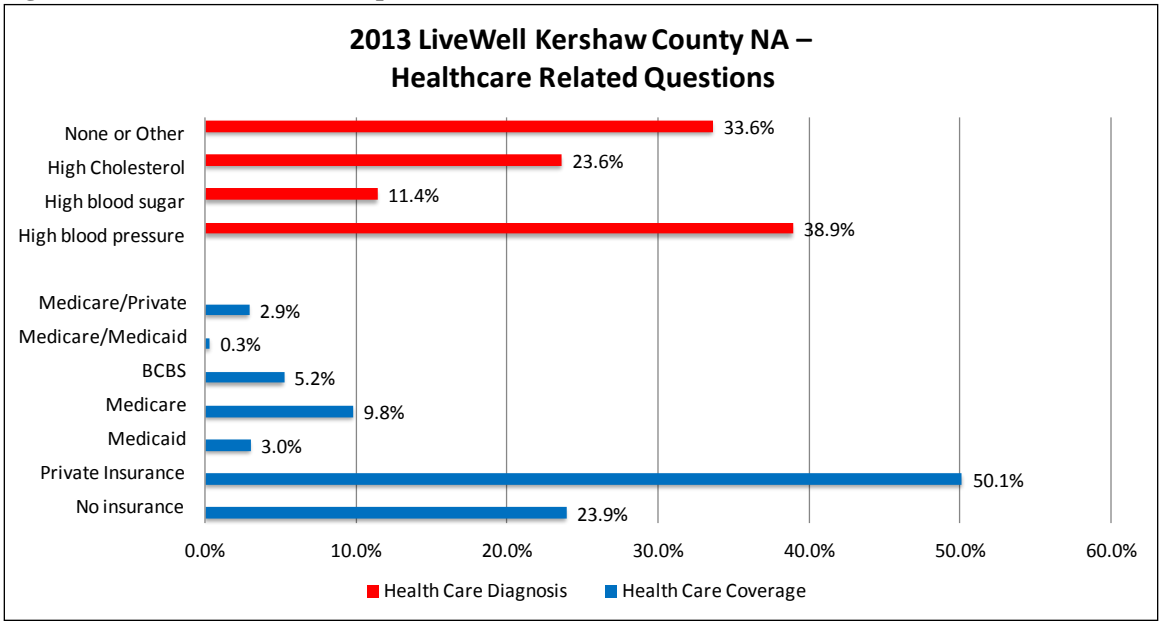


**Figure 6: Needs Assessment Graph**

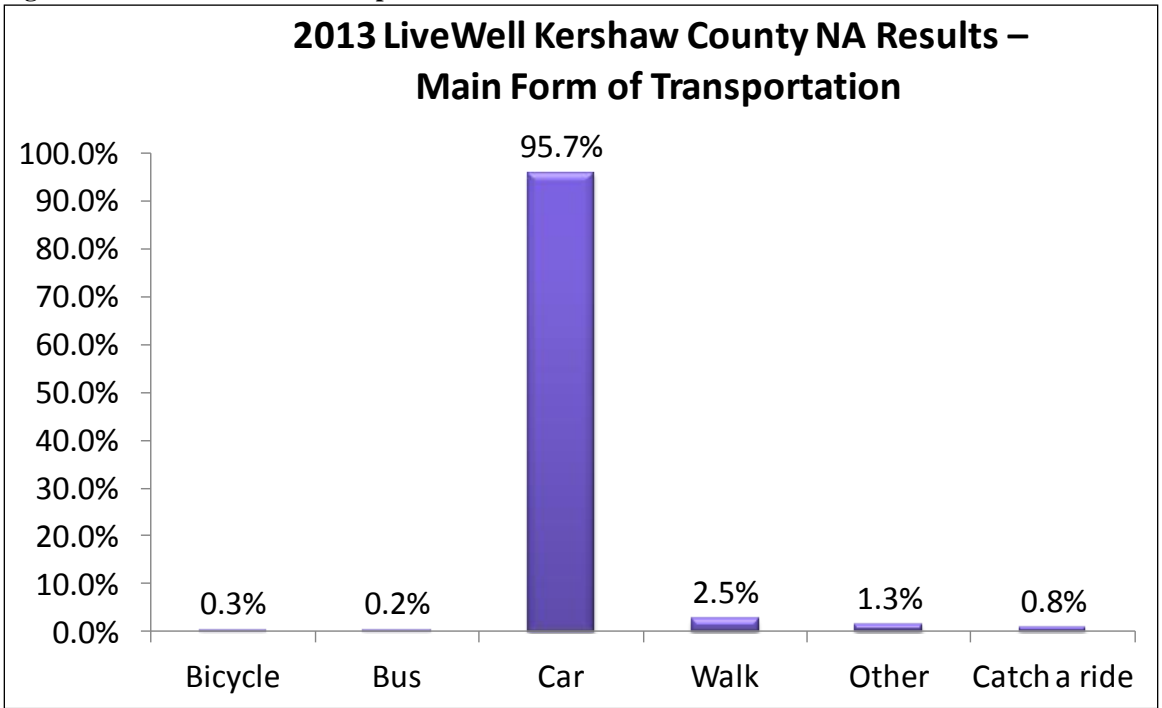


# NEEDS ASSESSMENT RESULTS

**Figure 7: Needs Assessment Graph**



**Figure 8: Needs Assessment Graph**



# NEEDS ASSESSMENT RESULTS

Figure 9: Needs Assessment Graph

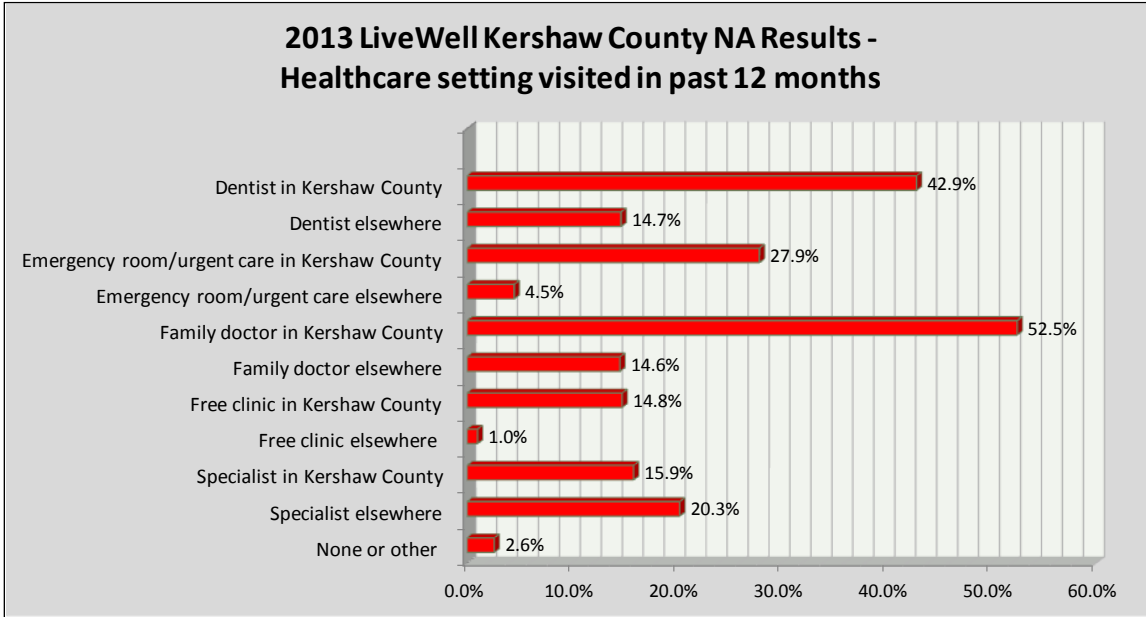
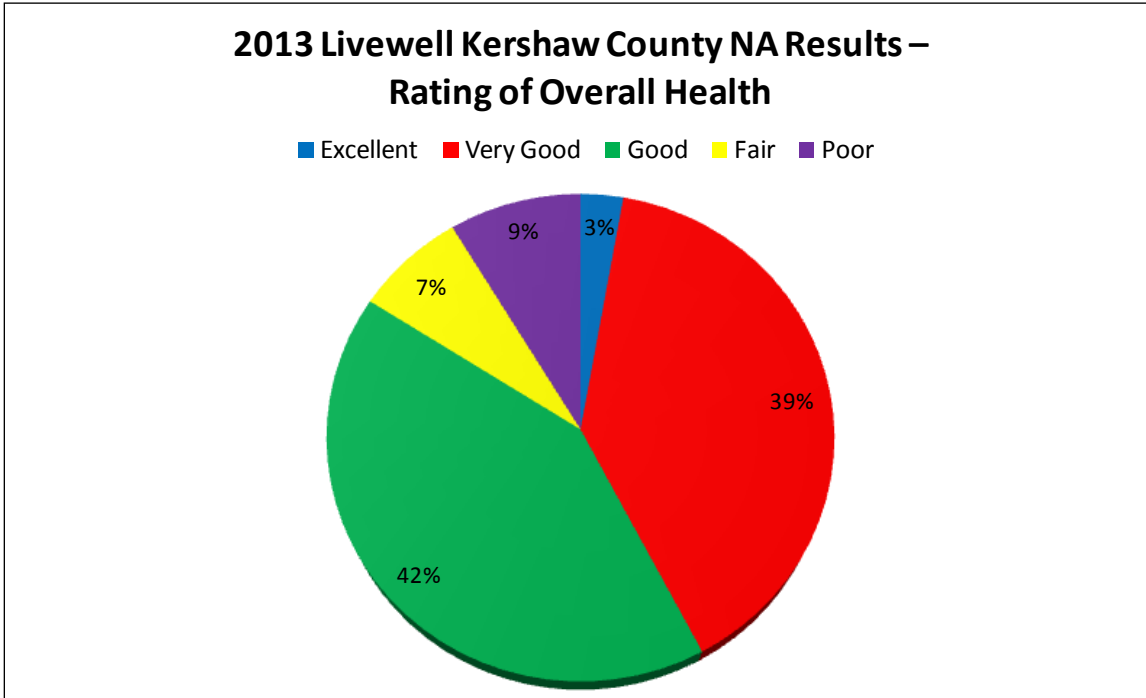
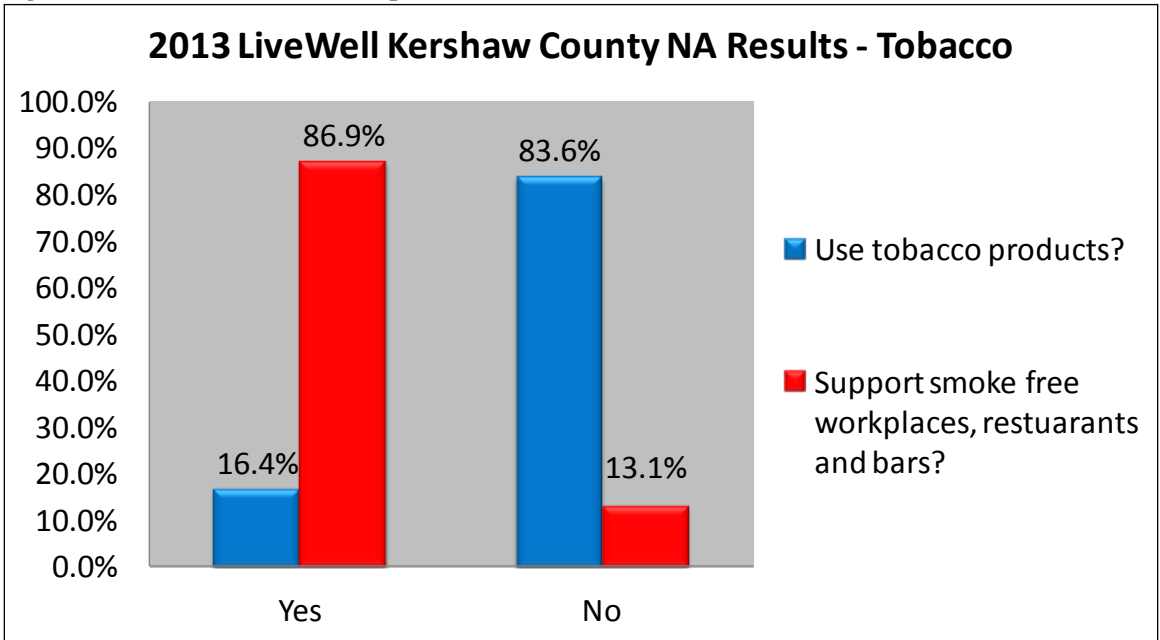


Figure 10: Needs Assessment Graph

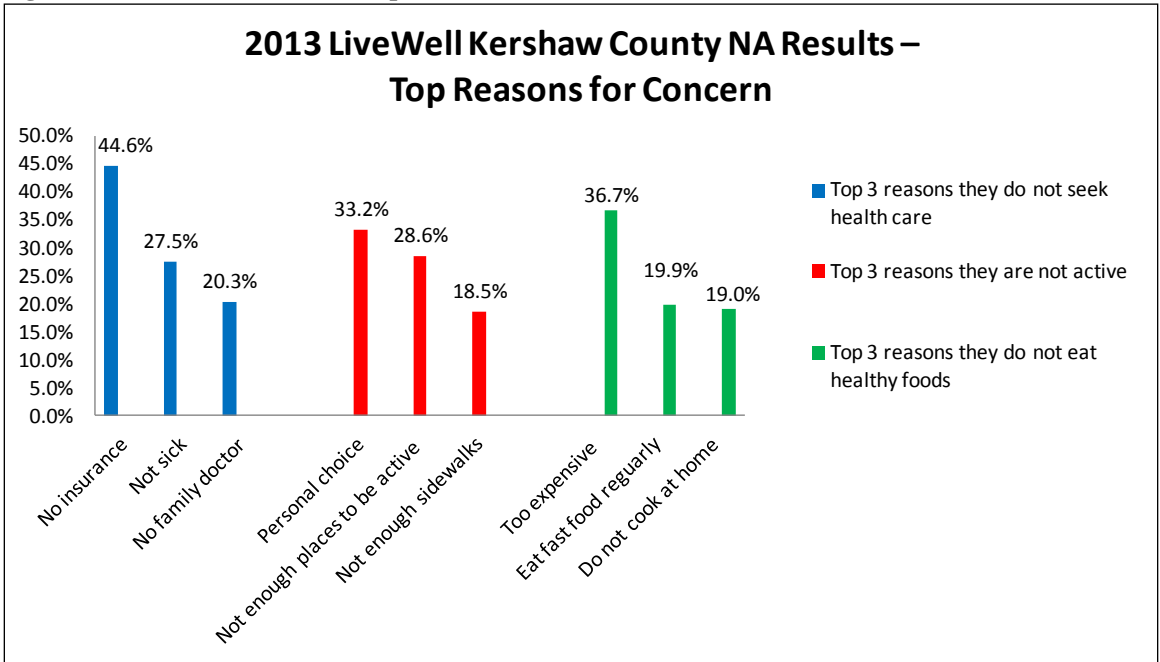


# NEEDS ASSESSMENT RESULTS

**Figure 11: Needs Assessment Graph**

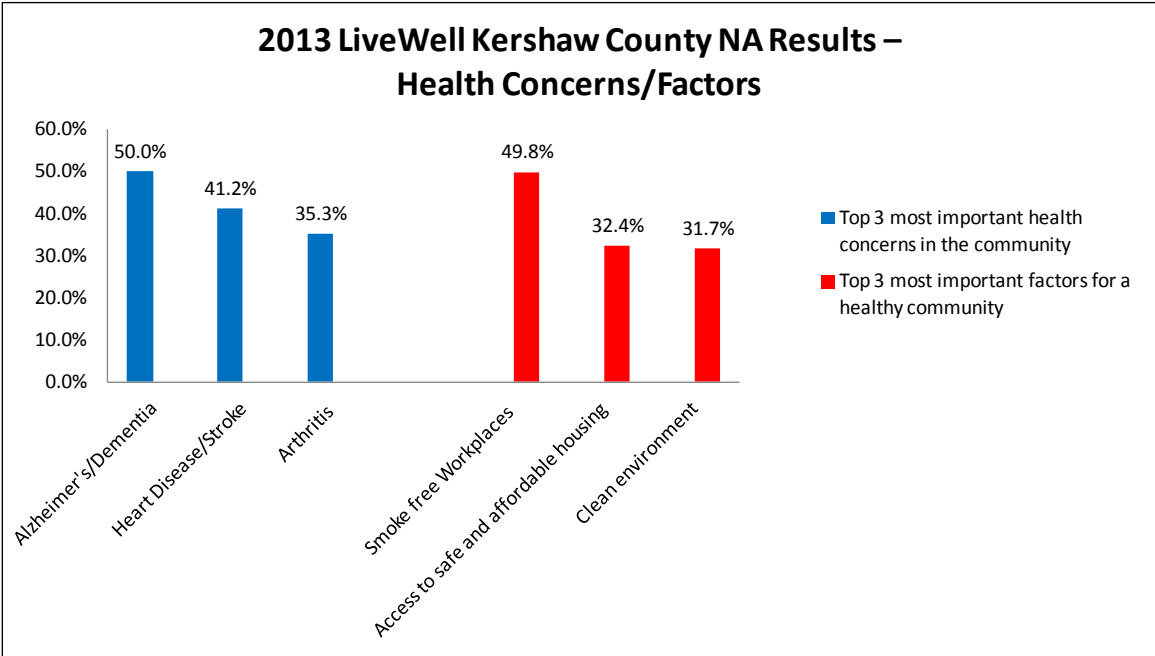


**Figure 12: Needs Assessment Graph**



# NEEDS ASSESSMENT RESULTS

Figure 13: Needs Assessment Graph



## Kershaw County Indicator Inventory

HEALTH FACTORS & OUTCOMES	INDICATOR GROUPS		INDICATORS/MEASURES	KC	SC	US	SOURCE/YEAR
Physical Environment	Environmental Quality	Drinking Water Safety	Percentage of population exposed to water exceeding a violation limit during the past year (2% Weight in health factors)	4%	2%	0%	CHR, Safe Drinking Water Information System, FY 2012
		Access to Recreational Facilities	Rate of recreational facilities per 100,000 population	6	9	16	CHR, County Business Patterns, 2010
			Percentage of population living within half a mile of a park	11%	14%	--	CHR, CDC Tracking Program 2010
		Healthy Foods	Percent of all restaurants that are fast-food establishments (2% Weight in health factors)	55%	49%	27%	CHR, County Business Patterns 2010
			Percent of population who are low-income and do not live close to a grocery store. (2% Weight in health factors)	7%	8%	1%	CHR, USDA, 2012
		Social and Economic Factors	Income and Poverty	Poverty	Percent of children under age 18 in poverty (10% weight in health factors)	27%	28%
Percent of persons below poverty level	15.8%				17%	--	US Census Bureau, 5 yr est. (2007-2011)
Percent of children enrolled in public schools that are eligible for free lunch	44%				42%	--	CHR, NCES 2011
WIC enrollment need met (pregnant women)	121%				121%	--	DHEC, PHSIS 2012
WIC enrollment need met (infants)	48%				52%	--	DHEC, PHSIS 2012
WIC enrollment need met (children)							DHEC, PHSIS 2012
Median household income	Median annual household income				\$41,055	\$42,477	--
Education	High school graduation		Percent of ninth grade cohort that graduates in 4 years (5% weight in health factors)	73%	74%	--	CHR, SC State Dept of Ed, 2010-2011

HEALTH FACTORS & OUTCOMES	INDICATOR GROUPS		INDICATORS/MEASURES	KC	SC	US	SOURCE/YEAR
	Employment	College education	Percent of adults aged 25-44 years with some post-secondary education (5% weight in health factors)	55%	58%	70%	CHR, ACS 5yr, 2007-2011
		Unemployment	Percent of population age 16+ unemployed but seeking work (10% weight in health factors)	9.5%	10.3%	5%	CHR, LAUS, 2011
		Commuting	Percent of the workforce that drives alone to work	81 %	83%		CHR, ACS 2007-2011
	Community Safety	Crime	Violent crime rate per 100,000 population (5% weight in health factors)	508	667	66	CHR, UCR, 2008-2012
			Deaths due to homicide per 100,000 population	7	8	--	CHR, NVSS 2004-2010
	Housing	Housing costs	Percent of households with housing costs >= 30% of household income  Median value of owner-occupied housing units	27%  \$112,000	31%  \$137,000	--  --	CHR, ACS 2007-2011  US Census Bureau, ACS 5 yr est. (2007-2011)
Social Support	Inadequate social support	Percent of adults without social/emotional support (2.5% weight in health factors)	22%	22%	14%	CHR, BRFSS 2005-2010	
Health Behaviors	Tobacco Use	Smoking	Percent of adults that report smoking >= 100 cigarettes and currently smoking (10% weight in health factors)	22%	21%	13%	CHR, BRFSS 2005-2011
			Percent of women who smoked during pregnancy	18.5%	11.5%		DHEC, PHSIS 2011
	Nutrition & Physical Activity	Overweight & obesity	Percent of adults that report a BMI >= 30 (7.5% weight in health factors)	32%	31%	25%	CHR, NDSS 2009
			Low-income preschool obesity rate	15.3%	11.4%	14%	DHEC, Food Environment Atlas 2009
		Physical activity	Percent of adults aged 20 and over reporting no leisure time physical activity (2.5% weight in health factors)	28%	28%	21%	CHR, NDSS 2009
			Percentage of adults that report doing physical activity or exercise during the past 30 days other than their regular job	73%	73%	--	DHEC, PHSIS 2008-2010
Nutrition	Percent of adults who report not eating 2+ fruits and 3+ vegetables daily	83.6%	82.6%	76.6%	DHEC, BRFSS 2009		
	Breastfeeding initiation	64.4%	65.7%	--	DHEC, PHSIS 2011		

HEALTH FACTORS & OUTCOMES	INDICATOR GROUPS		INDICATORS/MEASURES	KC	SC	US	SOURCE/YEAR
	Substance Abuse	Alcohol	Binge plus heavy drinking (2.5% weight in health factors)	14%	14%	7%	CHR, BRFSS 2005-2011
		Pregnancies and births	Teen birth rate per 1,000 female population, ages 15-19 (2.5% weight in health factors)	58	49	21	CHR, NVSS 2004-2010
	Sexual Activity	Sexually Transmitted Infections	Chlamydia rate per 100,000 population (2.5% weight in health factors)	541	573	92	CHR, NCHHSTP 2010
			Rate of Gonorrhea per 10,000 population	107.6	174.8	--	DHEC, PHSIS 2011
			Rate of Syphilis per 10,000 population	8	13.7	--	DHEC, PHSIS 2011
	Safety	Cars	Motor vehicle crash deaths per 100,000 population (2.5% weight in health factors)	31	24	12	CHR, NCHS 2004-2010
Clinical Care	Preventative Care	Cancer screening	Percent of diabetic Medicare enrollees that receive HbA1c screening (2.5 weight in health factors)	85%	85%	90%	CHR, DAHC 2010
			Percent of female Medicare enrollees that receive mammography screening (2.5% weight in health factors)	66%	69%	73%	CHR, DAHC 2010
		Prenatal care	Pregnant females receiving early and adequate prenatal care (Kotelchuck Adequate and Adequate +)	78.8	73.9	--	DHEC, PHSIS 2011
	Access to Care	Health insurance	Percent of population under age 65 without health insurance (5% weight in health factors)	20%	20%	11%	CHR, SAHIE 2010
			Uninsured children (18 and younger)	10%	10%	--	CHR, SAHIE 2010
		Health care providers	Ratio of population to primary care physicians (3% weight in health factors)	1,819:1	1,545:1	1,067:1	CHR, ARF 2011-2012
			Number of people per mental health provider	8,837:1	4,395:1	--	CHR, HRSA ARF 2011-2012
			Ratio of population to dentists (2% weight in health factors)	4,159:1	2,229:1	1,516:1	CHR, ARF 2011-2012
	Health care costs		Percent of adults who could not see a doctor in the past 12 months because of cost	13%	16%	--	CHR, BRFSS 2005-2011
			Price-adjusted Medicare spending per enrollee	\$9,479	\$9,141	--	CHR, Dartmouth Atlas of Health Care 2010
		Preventable hospital stays	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	82	64	49	CHR, Dartmouth Atlas of Health Care 2010



HEALTH FACTORS & OUTCOMES	INDICATOR GROUPS	INDICATORS/MEASURES	KC	SC	US	SOURCE/YEAR	
Health Outcomes	Illness (Morbidity)	General health	Percent of adults reporting fair or poor health (age-adjusted) (10% weight in health outcomes) 3.1	15% 3.7	16% 2.6	10% 2.6	CHR, BRFSS 2005-2011 CHR, BRFSS 2005-2011
		Mental health	Average number of mentally unhealthy days reported in past 30 days (age-adjusted) [10% weight in health outcomes]	2.9	3.6	2.3	CHR, BRFSS 2005-2010
		Birth outcomes	Percent of live births with low birthweight (< 2500 grams) [20% weight in health outcomes]	9.5%	10.1%	6%	CHR, NVSS 2004-2010
		Chronic disease	Percent of adults aged 20 and above with diagnosed diabetes	11%	11%	--	CHR, NDSS 2009
			Percentage of individuals that have been told by a doctor they have high blood pressure	32.2 158.3	33.4 184.2	--	DHEC, PHSIS 2008-2010 DHEC CCD 2011
			Age adjusted death rate due to heart disease per 10,000 population	208.4	181.2	--	DHEC CCD 2011
			Age adjusted cancer rate per 10,000 population	14.6	33.0	--	DHEC SCAN 2011
	Communicable disease	Age adjusted rate of deaths due to Alzheimer's per 100,000 population (2000 standard population)	76	31	25	DHEC Asthma Fact Sheet, 2010	
		Rate of asthma hospitalization in children ages 0-4 per 100,000 population	298	361	--	CHR, NCHHSTP 2009	
	Accidents	Number of people living with HIV/AIDS per 10,000 population	26.2 176.3	20.8 132.6	--	SCHA 2008-2010 SCHA 2008-2010	
		Leading cause of death due to accidents per 10,000 youth ages 1-14 years Leading cause of death due to accidents per 10,000 persons ages 15-24 years					
	Deaths (Mortality)	Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted) [50% weight in health outcomes]	8,692	8,448	5,317	CHR, NVSS 2008-2010
		Infant mortality	Crude rate of mortality for infants under age 1	667	796	--	CHR, CDC WONDER 2006-2010

HEALTH FACTORS & OUTCOMES	INDICATOR GROUPS		INDICATORS/MEASURES	KC	SC	US	SOURCE/YEAR
		Child mortality	Crude mortality rate for deaths under age 18	65	71	--	CHR, CDC WONDER 2007-2010

## Source Legend

Acronym	Full-name
ACS	American Community Survey
ARF	Area Resource File
BRFSS	Behavioral Risk Factor Surveillance System
CDC WONDER	Centers for Disease Control and Prevention's Wide-ranging Online Data for Epidemiologic Research mortality data
CHR	County Health Rankings
DAHC	Dartmouth Atlas of Health Care
DHEC CCD	DHEC Coordinated Chronic Disease Fact Sheet (for Kershaw County)
DHEC SCAN	Department of Health and Environmental Control's South Carolina Community Assessment Network
HRSA	Health Resources and Services Administration
LAUS	Local Area Unemployment Statistics
NCES	National Center for Education Statistics
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCHS	National Center for Health Statistics
NDSS	National Diabetes Surveillance System
NVVS	National Vital Statistics System
PHSIS	Public Health Statistics and Information Services
SAHIE	Small Area Health Insurance Estimates
SAIPE	Small Area Income and Poverty Estimates (via Census Bureau)
SCHA	South Carolina Hospital Association
UCR	FBI's Uniform Crime Reports
USDA	United States Department of Agriculture

**Novant Health  
Gaffney Medical Center**

**Health Priorities Focus Group  
Summary**

***Supplement to the Community Health  
Needs Assessment***



## FOCUSGROUPAGENDA

### Welcome/Dinner

Brian Yates, Vice President, Novant Health Gaffney Medical Center

### Background/Introductions –

Whose ‘business’ is this anyway? – Lillie Hall, DHEC Upstate

### Community Health Indicators – Data Presentation

Page Rogers, DHEC Upstate

### Data Discussion and Selection of Health Priorities

Facilitated by Lillie Hall and Page Rogers

### Questions/Closing



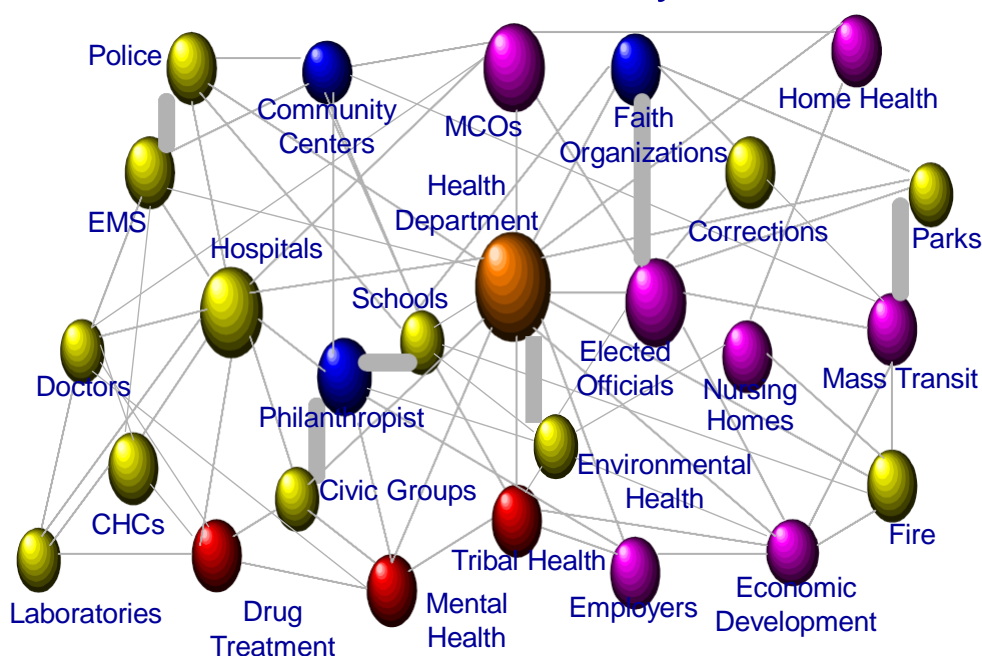
## Purpose:

This focus group was conducted to comply with the revised IRS Form 990, Schedule H requirements and will be captured in the overall Community Health Needs Assessment (CHNA) and Improvement Plan for the Gaffney Medical Center (Cherokee County, SC).

## Overview:

Non-profit hospitals are required to provide benefits to the communities they serve to keep a tax-exempt status. Historically, much of the hospitals' community benefit activities have been charity care and other forms of uncompensated care. This accountability was heightened under the Affordable Care Act with the new requirements to conduct CHNAs, develop implementation strategies and consistently promote and evaluate those plans every three years. The benefits of the new requirements go beyond improving health – they include enhanced accountability for hospitals, more effective use of resources, and building community capacity and engagement in addressing health issues impacting their constituents.

## Local Public Health System



The CHNA process offers an opportunity for the entire community to work together to collectively improve health. Participants can include health systems, health departments and other government agencies, community organizations, employers, the faith community, United Ways and other non-profits, local funders, academic institutions, and other community leaders. Adequate community assessments utilize the 'Egg Diagram' of the Local Public Health System to realize that health is everyone's 'business', so everyone should work together to assess the health, analyze the data, identify priorities and formulate solutions to the community's needs.

## Participation and Process:

Novant Health Gaffney Medical Center partnered with DHEC Upstate Public Health Region to sponsor the focus group. The partnership afforded the opportunity to include several of the suggested groups and individuals noted in the overview. Each individual listed on the participant list received an invitation via phone and /or email. On arrival, participants were invited to dinner and welcomed by Mr. Brian Yates, Vice President of Operations at Novant Health Gaffney Medical Center. After the welcome, the facilitator, Lillie Hall, led a small discussion about why it's important to focus and prioritize health needs. As an example, the following info-graphic regarding "What health factors make us healthy" and "What we spend on being healthy" was shared with the group. Healthy behaviors make up half of the factors that make us healthy, but we spend more than 80% of US dollars are being spent on medical services. Participants then received a presentation of secondary data, collected on Cherokee County, from Page Rogers.

### Overall Public Health Topics Included:

- Access to Health Services
- Chronic Diseases Clinical
- Preventive Services
- Infectious Disease
- Maternal, Infant and Child Health
- Nutrition, Physical Activity and Obesity
- Tobacco

### What Makes Us Healthy



### What We Spend On Being Healthy



### Additional Data Resources shared:

Link to Spartanburg, Cherokee and Union BMI Reports:  
[www.dhec.sc.gov/health/region2/ch\\_obesity.htm](http://www.dhec.sc.gov/health/region2/ch_obesity.htm)

Link to Cherokee County BMI Report:  
[www.dhec.sc.gov/health/region2/docs/Cherokee\\_Report\\_20130213.pdf](http://www.dhec.sc.gov/health/region2/docs/Cherokee_Report_20130213.pdf)

Link to Cherokee County Data Sheets:  
[www.dhec.sc.gov/health/epidata/cherokee.htm](http://www.dhec.sc.gov/health/epidata/cherokee.htm)

Link to County Health Rankings Data:  
[www.countyhealthrankings.org/app/south-carolina/2013/cherokee/county/outcomes/overall/snapshot/by-rank](http://www.countyhealthrankings.org/app/south-carolina/2013/cherokee/county/outcomes/overall/snapshot/by-rank)

[Participation and Process Continued]

After the data presentation, Lillie Hall led a data discussion that concluded with the selection of health priorities. Participants were asked “What do you feel are the Public Health concerns/issues in Cherokee County?” Next they were asked to consider resources available, what entity, if any, were working on the concern and write a potential response (not solution) to that concern. All of this information was captured on half sheets and discussed as a group. The following Public Health categories and subcategories were discussed:

- **Access to Healthcare**
  - Lack of transportation
  - Lack of knowledge of resources available
  - Lack of Physicians who accept Medicaid patients and
  - Lack of insurance
- **Obesity**
  - Obesity in general
  - Lack of exercise resources
  - Diet/nutrition education
  - Childhood obesity concerns
- **Chronic Disease**
  - Diabetes (Education and Resources)
  - Stroke
  - Cancer (Education and Resources)
  - High Blood Pressure
- **Maternal and Child Health**
  - Teen Pregnancy
    - Access to Prenatal Care
    - Infant Mortality
- **Mental Health**
- **Social/Economic Health**
  - General Issues (Jobs, Education, etc.)
  - Educational opportunities for drop-outs
- **Alcohol, Tobacco and Other Drugs**
  - Drug Abuse
  - Smoking/Tobacco
    - Smoking cessation
    - Teen Smoking concerns
- **Infectious Disease**
  - STD/HIV
- **Other**
  - Sleep Apnea
  - Apath





[Participation and Process Continued]

In the second phase of the session, the group categorized the concerns as noted on the previous page. Finally, participants were given three (3) color dots to ‘vote’ for the top three (3) concerns they felt were important to be included in the hospitals’ implementation strategy. This data will inform those participating in the strategic planning process and will assist in the broad-thinking capacity needed to develop the implementation strategies. The top three (3) public health concerns and potential responses, in order of highest priority were:

1. Access to Healthcare

- a. Education on available services and how to take advantage of the services
- b. Conduct an awareness forum periodically at the most popular place where people gather
- c. Work through faith-based councils to get the information and education out to the public
- d. Utilize the emergent care facilities for certain services; many are able to access them
- e. Hold ‘clinics’ throughout the county
- f. Collaborate with the transportation authority somehow to provide transportation (i.e. offer to pay 1 day/week transportation for some chronic disease patients, etc.)
- g. Offer more incentives to MD’s to accept Medicaid clients
- h. Increase reimbursement for Medicaid clients
- i. Partner with an FQHC to increase availability
- j. Extend PCP hours
- k. Consider Telemedicine programs
- l. Increase community health screenings
- m. Influence public transportation plans
- n. Work through employers to promote insurance on the job via the Affordable Care Act; promote incentives to companies for referrals to the hospital

2. Obesity

- a. More education on lifestyle changes
- b. Healthier food options offered at more places
- c. Promote healthier eating options in schools
- d. Partner with schools to provide education/programs for healthier living
- e. Collaborate with local foundations (specifically the Fullerton Foundation) on potential programs – Childhood Obesity pilot program discussed at the group session.
- f. More opportunities for exercise; exercise program in the schools
- g. Education on effects of treatment for chronic disease; relation to obesity
- h. Healthy cooking classes at the hospital
- i. Partner with Trail programs (i.e. Limestone College)

3. Smoking/Tobacco

- a. Limit access to the product; increase prices?
- b. Limit areas allowed to smoke
- c. Consider peer pressure programs for youth
- d. Promote more smoke-free environments in the community
- e. Promote a public ordinance

[Participation and Process Continued]

Other concerns/issues that received significant votes, in order of priority, were:

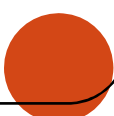
4. Diabetes
  - a. Education through the hospital and DHEC
  - b. More screening
  - c. Resources at Gaffney Medical and the ADA
  - d. Do public service campaigns
5. Teen Pregnancy
  - a. More education and counseling
  - b. Campaign for the importance of prenatal care
  - c. Work more on infant mortality

After the voting process concluded, the facilitator led general discussion regarding the concerns selected as the top three (3) priority areas. The following notes were captured:

- Access to Care
  - The group felt that public transportation is a major issue
  - There is a lot of inappropriate use of the ER
  - No emergent care available to provide a safety net for the ER
- Obesity
  - Too many fast food locations
  - No education on the preparation of healthier food options
  - Need more access to farmer's markets
  - Need finance education and budgeting to plan healthy meals
  - A large number of the obese population has DIABETES
  - Maybe partner with the YMCA to offer discounts
- Diabetes
  - Should have been selected because most chronic disease is secondary to it
  - Gaffney Medical Center has a Diabetes program
  - Number one issue with Diabetic patients is eye concerns
  - Seeing large numbers of Type 2 in children
  - Need better Diabetic nutrition education

Additional notes:

Hard copies of the aforementioned data and notes will be forwarded to Novant Health Gaffney Medical Center for filing. If you have any questions regarding any information presented on this summary, please contact Lillie Hall, Community Systems Director, DHEC Upstate Public Health Region at 864-372-3189 or via email at [halllm@dhec.sc.gov](mailto:halllm@dhec.sc.gov).



# Supplemental Links

## **Community Health Status Report: Fayette County 2011**

This is an example of a final community health assessment report for Lexington Fayette County Health Department.

<http://www.lexingtonhealthdepartment.org/Portals/0/strategic%20community%20plans/CommHealthStatusReport06292012.pdf>

## **Community Assessment Report -Lexington-Fayette County Health Department**

This document is a compilation of all of the community assessment information that has been compiled at the Lexington-Fayette County Health Department and will serve as the foundation for the community health improvement plan for the Lexington-Fayette County area.

[http://www.lexingtonhealthdepartment.org/Portals/0/strategic%20community%20plans/Community%20Assessment%20Report\\_FINAL%205-14-12.pdf](http://www.lexingtonhealthdepartment.org/Portals/0/strategic%20community%20plans/Community%20Assessment%20Report_FINAL%205-14-12.pdf)

## **Healthy Capital Counties 2012 Indicators**

This is an explanation of how to identify strategic issues/ indicators and how to organize them into a meaningful inventory.

[http://www.healthycapitalcounties.org/uploads/9/1/6/3/9163210/2012\\_indicators\\_final\\_table.pdf](http://www.healthycapitalcounties.org/uploads/9/1/6/3/9163210/2012_indicators_final_table.pdf)

# **Phase 4: Identify Strategic Issues**

# Fishbone Diagrams

Also called: **Cause and Effect Diagrams**

Fishbone diagrams allow individuals and teams to identify, explore, and display all possible root causes related to a problem or condition. Fishbones allow a team to focus on the content of the problem, rather than the history of the problem, and the causes of the problem rather than the symptoms of the problem.

## Types of Fishbone Diagrams

### Dispersion Analysis

Dispersion analysis categorizes **types of problems**, and continually asks why a problem happens until out of answers.

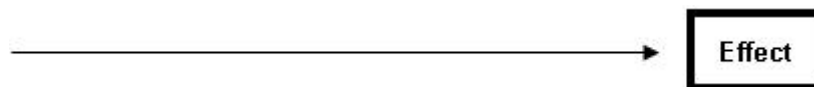
### Process Clarification

Process clarification categorizes **process steps**, and continually ask why a step occurs until out of answers.

## How to Construct a Fishbone Diagram

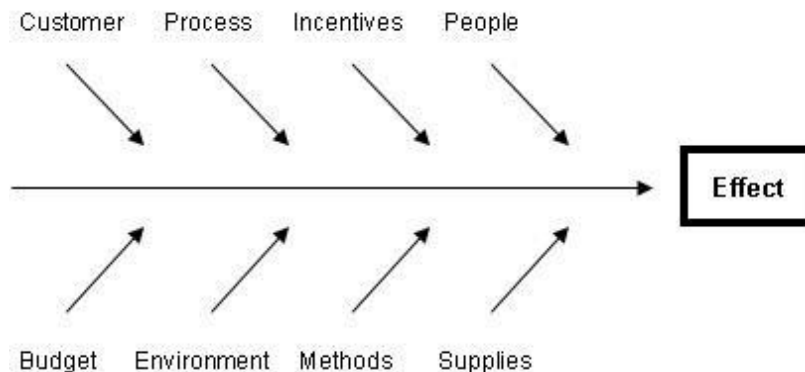
### 1. Problem Statement

Place the problem statement at the head of the "fish." This is the end effect, for which you will start to map out problem causes. Draw a line toward the head of the fish--this is the fish's "backbone."



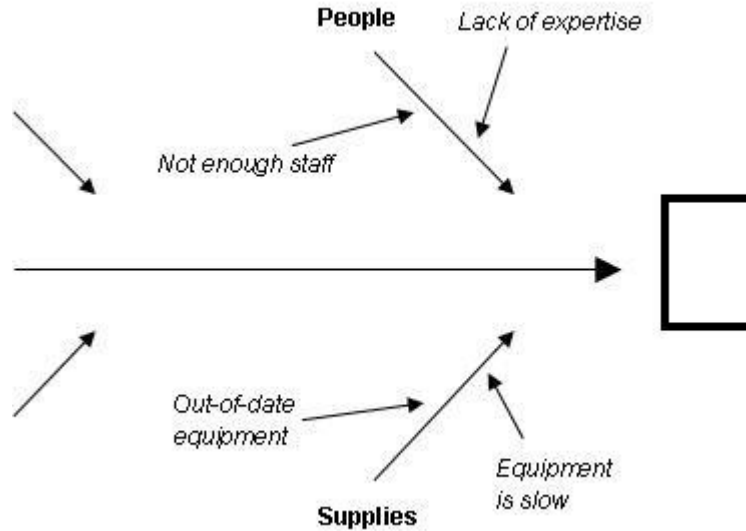
### 2. Categorization

Start listing major steps in the production or service process, and connect them to the backbone in "ribs." There is no specific number of steps or categories you might need to describe the problem; some common categories are listed below.



### 3. Contributing Factors

Brainstorm possible problem causes, and attach each to the appropriate rib.



When brainstorming, your team might find it helpful to place ideas on category ribs as they are generated, or to brainstorm an entire list of ideas and then place them on ribs all at once.

Ideally, each contributing factor would fit neatly into a single category, but some causes may seem to fit into multiple categories. If you have a contributing factor that fits into more than one category, place it in each location, and see whether, in the end, considering that factor from multiple points of view has made a difference.

### 4. Why?

As you list a factor, repeatedly ask your team why that factor is present:

- Why does staff lack expertise? (Because we don't attend training.)*
- Why don't we attend training? (Because we don't have the funding.)*
- Why don't we have the funding? (Because we haven't applied for grants.)*
- Why don't we apply for grants? (Because we're unaware of sources.) Etc.*

Sometimes this asking process is called the "Five Whys," as five is often a manageable number to reach a suitable root cause. Your team may need more or less than five whys.

### 5. Many Ribs: Deeper Causes

You may end up with multiple branches off of each successively smaller rib. Your team might lack expertise, for example, because of a lack of training, but also because you didn't hire the right people for the job. Treat each contributing factor as its own "mini-rib," and keep asking why each factor is occurring.

Continue to push deeper for a clear understanding. While you could likely brainstorm all day, however, it is important to know when to stop to avoid frustration. A good rule of thumb: When a cause is controlled by more than one level of management, remove it from the group.

## 6. Test for Root Causes

Test for root causes by looking for causes that appear repeatedly within categories or across major categories.

*(Hint: Use **check sheets** to determine the frequencies of various causes, and **scatter plots** to test the strength of cause-effect correlation.)*

### Further Reading

#### More Information

MDH: Root Cause Analysis Toolkit: <http://www.health.state.mn.us/patientsafety/toolkit/index.html>

American Society for Quality (ASQ): Fishbone Diagram:  
<http://asq.org/learn-about-quality/cause-analysis-tools/overview/fishbone.html>

Improhealth Collaborative: Fishbone Diagram:  
[http://www.improhealth.org/fileadmin/Documents/Improvement\\_Tools/Fishbone\\_diagram.pdf](http://www.improhealth.org/fileadmin/Documents/Improvement_Tools/Fishbone_diagram.pdf)

### Examples of Fishbone Diagrams

Inter-Agency Partnership: Soliciting Input and Advice from Key Stakeholders:  
[http://www.health.state.mn.us/divs/cfh/ophp/consultation/qi/projects/cases/clay\\_stakeholders.html](http://www.health.state.mn.us/divs/cfh/ophp/consultation/qi/projects/cases/clay_stakeholders.html)

Kandiyohi County: Engaging Community Partners in a Community Leadership Team:  
[http://www.health.state.mn.us/divs/cfh/ophp/consultation/qi/projects/cases/kandiyohi\\_communityleadership.html](http://www.health.state.mn.us/divs/cfh/ophp/consultation/qi/projects/cases/kandiyohi_communityleadership.html)

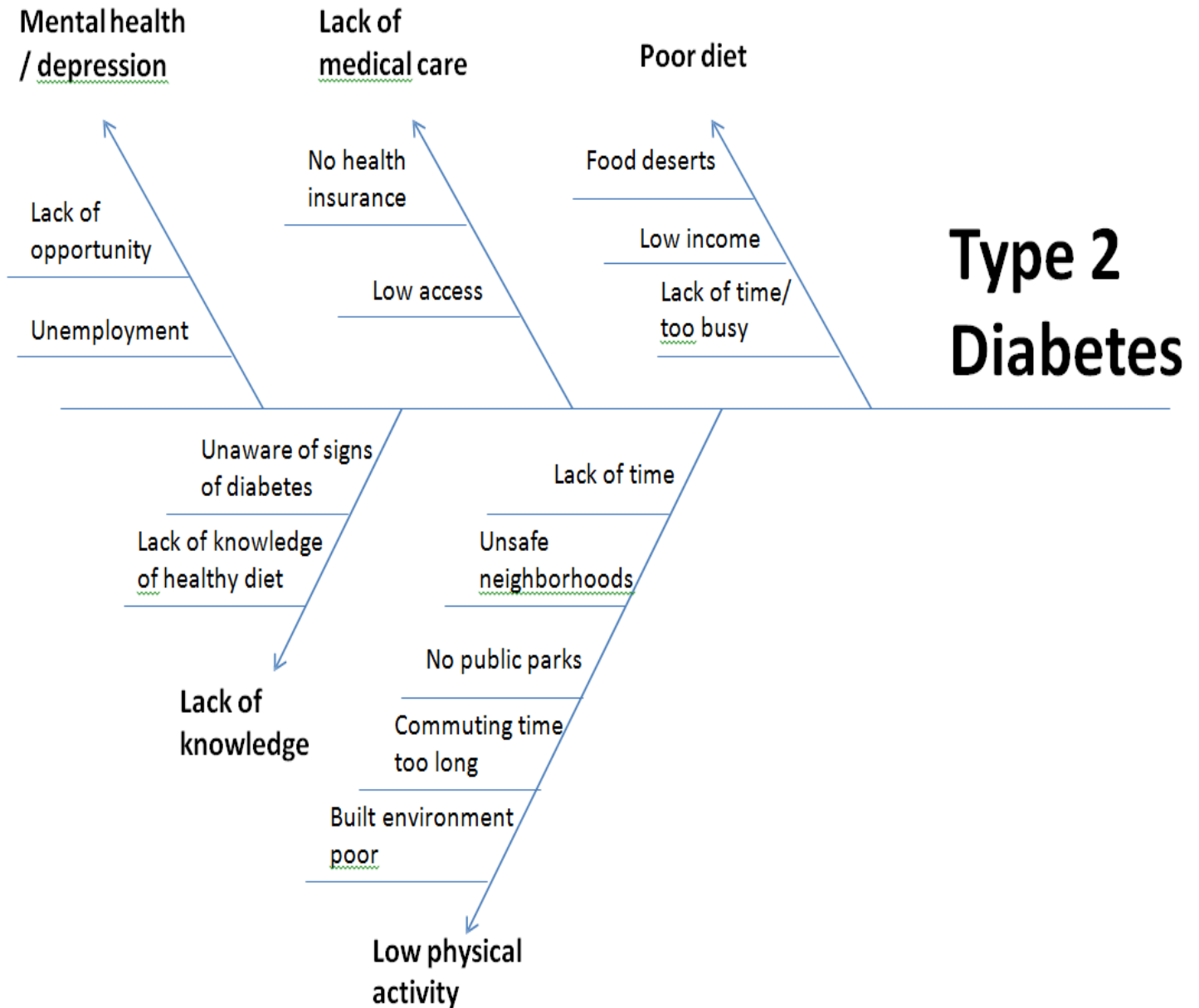
AIDS Training and Education Centers: Using a Fishbone Diagram to Assess and Remedy Barriers to Cervical Cancer Screening in Your Healthcare Setting: <http://www.aidsetc.org/aidsetc?page=etres-display&resource=etres-347>

West Central Public Health Initiative: Immunization Quality Improvement Project:  
<http://www.kalhd.org/attachments/wysiwyg/5/MullenWCPHStoryboard.pdf>

### Source

Public Health Memory Jogger: [http://www.goalqpc.com/shop\\_products\\_detail.cfm?PID=754](http://www.goalqpc.com/shop_products_detail.cfm?PID=754)

## NAACHO Fishbone Diagram Example



How to facilitate the fishbone process:

<http://www.health.state.mn.us/divs/cfh/ophp/consultation/qi/resources/toolbox/fishbone.html>



## NAACHO Prioritization Process

### Tip Sheet: Prioritizing Issues in a Community Health Improvement Process

Prioritization is a key step in a community health improvement process that serves as a natural transition from focusing on the findings of the community health assessment (CHA) to developing a community health improvement plan (CHIP). Prioritization helps communities focus on key issues in order to maximize impact and use their resources as efficiently as possible. **It is generally recommended that a community choose no more than three-five priorities to focus on within one community health improvement process cycle.** Many communities who have chosen more than that have found it difficult to make progress and to measure impact. This tip sheet provides a brief overview of key tips to consider when selecting community health improvement priorities.

#### Tip #1: Identifying Criteria

There are many processes that can be used in determining priorities for community health initiatives. Regardless of the process(es) used, a diverse set of criteria should be considered and used in a priority selection process. To ensure community and stakeholder ownership of the selected priorities and increase the likelihood of action to improve health, it is vital to include stakeholders in choosing criteria for use in prioritizing issues. There are a variety of ways that the criteria important to stakeholders can be identified including, but not limited to conducting a simple brainstorming session, a consensus workshop, or creating an Affinity Diagram.

More information on these types of processes can be found in *The Public Health Memory Jogger II* and in the [Prioritizing Issues](#) webinar available in the [CHA/CHIP Resource Center](#).

The following are frequently used criteria that should be considered in determining priorities for community health improvement:

- **Size:** Number of persons affected, taking into account variance from benchmark data and targets.
- **Seriousness:** Degree to which the problem leads to death, disability, and impairs one's quality of life.
- **Trends:** Whether or not the health problem is getting better or worse in the community over time.
- **Equity:** Degree to which specific groups are affected by a problem.
- **Intervention:** Any existing multi-level public health strategies proven to be effective in addressing the problem.
- **Feasibility:** Ability of organization or individuals to reasonably combat the problem given available resources. Related to the amount of control and knowledge (influence) organization(s) have on the issue.
- **Value:** The importance of the problem to the community.
- **Consequences of Inaction:** Risks associated with exacerbation of problem if not addressed at the earliest opportunity.
- **Social Determinant/ Root Cause:** Whether or not a problem is a root cause or social determinant of health that impacts one or more health issues.

## Tip #2: Planning for a Successful Issue Prioritization Process

Issue prioritization is the job of the key organizations leading the improvement process as well as its partners and community members. Meaningful engagement of partners and community is critical in the issue prioritization process as it increases the likelihood for support in implementation of planned initiatives and ensures that the chosen priorities are those that reflect the experiences of those working, living, playing or learning in the community. To ensure meaningful engagement of community members and partners, consider the following actions in planning your prioritization process:

- Be strategic and representative in who participates in the prioritization.
- Always refer to objectives and purposes of prioritization at the outset of the meeting and as needed to keep the attendees focused.
- Set expectations for the meeting at the very beginning.
- Develop an agenda for prioritization meeting(s) with input from others.
- Promote the meeting in advance and encourage RSVPs.
- Ask for volunteers for various roles ,i.e. note taker, tabulator of results, etc.
- Strike the appropriate balance between having a framework for the process, but also remaining flexible to participants' desires and needs.
- Choose an objective facilitator that is perceived by participants as neutral and unbiased toward a particular issue.
- Ensure that attendees feel as if it is their process and not one being forced upon them.

When working with many individuals and organizations, barriers that impede the decision making process may arise. It is important to plan for, recognize, and overcome these barriers to move forward in your prioritization process. Some potential barriers include the following:

- Prioritization skewed by those in attendance.
- Attendance is less than what was expected.
- Attendees do not like criteria or proposed process.
- Attendees debate the outcome of the prioritization.
- Certain individuals are upset that their issue is not one of the top issues.
- New issues are suggested for consideration, even if data clearly indicates that it is not a significant issue.
- Group is unwilling to make a final decision on top priorities
- Group takes on too many priorities.

### Tip #3: Using Tools in Issue Prioritization

The following are examples of some tools that are frequently used in issue prioritization.

#### Control and Influence

This is a conceptual tool to guide teams in deciding upon priorities. For any particular issue, examine your group’s and partners’ level of control and knowledge of the issue. This tool helps to understand where control lies, where assistance is needed, where you can influence only, and what to stay away from. **Your priorities should focus on issues in which you have control and knowledge.**

	Control	No Control
Knowledge	Do It	Influence
No Knowledge	Get Help	Stay Away

#### Prioritization Matrix

A prioritization matrix, one of the most commonly used tools in identifying priorities, can help if there are especially difficult priorities to choose from or if an organization or community is restricted to only one priority health issue. This tool is ideal when health problems are considered among a large number of criteria.

##### How to Use a Prioritization Matrix:

1. Take topics/ issues and ask: Does X (which is the column of the matrix) contribute more than Y (which is listed in the row of the matrix) in achieving the goal, based on the specific criterion?
2. Once your group has agreement on the answer, then decide- the relative amount of contribution :
  - a. 1= equally important (i.e. X and Y are equally important)
  - b. 5= significantly more important
  - c. 10= exceedingly more important
  - d. 1/5= significantly less important
  - e. 1/10= exceedingly less important
3. Assign agreed upon value to the issue contributing more and the reciprocal score to the other. (e.g. engage community is 10 times more important than immunization; immunization is only 1/10 as important as engaging community)
4. Total the scores by row and prioritize the issues, highest to lowest. Then, develop summary matrix to express results after matrices for all criteria are complete. (e.g. immunization 1<sup>st</sup> priority, food is 2<sup>nd</sup>, family planning is 3<sup>rd</sup>, etc.)

##### Example of Prioritization Matrix (each issue against Importance criterion):

	1. Immu.	2. Engage Commu.	3. CHIP	4. Food	5. Family Planning	Row Total
1. Immu.		10	1	1	5	17
2. Engage Community	1/10		1	1/5	1/5	1.5
3. CHIP	1	1		1/5	1	3.2
4. Food	1	5	5		5	16
5. Family Planning	1/5	5	1	1/5		6.4

## ●●● 'Dotmocracy' Method (Quick and Colorful) ●●

This is a group voting process used to prioritize based on criteria. This tool makes group decision making an easier and faster process, especially for big groups. To complete this process, the group should use the following procedure:

1. Identify options and post them on a wall or board.
2. Participants get selected number of votes which are indicated by 'dots' or stickers).
3. Review criteria for voting with participants.
4. Participants place their 'dots' by their choices based on criteria discussed.
5. Tabulate the number of 'dots' for each option to show results. Those issues receiving most dots indicates them as priority issues.

### Multi-Voting Technique

Multi-voting is a quantitative tool used when a long list of health issues needs to be narrowed down. This can be accomplished in any manner where you can quickly tabulate votes such as hand-raising or using wireless voting technology. If you choose to use this technique, this sequence should be followed:

1. Round 1 Vote – Each participant votes for their highest priority items.
2. Update List – Health problems with highest votes remain on the list (problems with votes equivalent to or more than 50% of engaged participants).
3. Round 2 Vote – Each participant votes for their highest priority item from condensed list (votes per person limited to half the number of items remaining).
4. Repeat – Process repeated until list narrowed down to desired number of health priorities.

#### Example of Three Round Multi-Voting Technique

Health Indicator	Round 1 Vote	Round 2 Vote	Round 3 Vote
Collect and maintain reliable, comparable, and valid data	√√√√	√√	
Evaluate public health processes, programs, and interventions.	√√√√	√√√√	√√√√
Maintain competent public health workforce	√√		
Implement quality improvement of public health processes, programs, and interventions	√√√√	√√	
Analyze public health data to identify health problems	√√		
Conduct timely investigations of health problems in coordination with other governmental agencies and key stakeholders	√√		
Develop and implement a strategic plan	√√√√	√√√√	√√
Provide information on public health issues and functions through multiple methods to a variety of audiences	√√		
Identify and use evidence-based and promising practices	√√		
Conduct and monitor enforcement activities for which the agency has the authority	√		
Conduct a comprehensive planning process resulting in a community health improvement plan	√√√√	√√√√	√√
Identify and implement strategies to improve access to healthcare services	√√√		√√

Red = Round 1 Elimination Green = Round 2 Elimination Blue = Round 3 Elimination

## Hanlon Method

This is a quantitative tool that objectively ranks specific health problems based on the criteria of seriousness, magnitude and effectiveness. Below is a brief description of how to use this method.

1. Give each health problem a numerical rating on a scale of 0-10 for each of the three criterion shown in the columns. Below is an example of how this can be established.

Rating	Size of Health Problem (% of population w/health problem)	Seriousness of Health Problem	Effectiveness of Interventions
9 or 10	>25% (STDs)	Very serious (e.g. HIV/AIDS)	80% - 100% effective (e.g. vaccination program)
7 or 8	10% - 24.9%	Relatively Serious	61% - 80% effective
5 or 6	1% - 9.9%	Serious	41% - 60% effective
3 or 4	.1% - .9%	Moderately Serious	21 - 40% effective
1 or 2	.01% - .09%	Relatively Not Serious	5% - 20% effective
0	< .01% (Meningococcal Meningitis)	Not Serious (teen acne)	<5% effective (access to care)
<b>Guiding considerations when ranking health problems against the 3 criteria</b>	Size of health problem should be based on baseline data collected from the individual community.	Does it require immediate attention? Is there public demand? What is the economic impact? What is the impact on quality of life? Is there a high hospitalization rate?	Determine upper and low measures for effectiveness and rate health problems relative to those limits.

2. **Apply the 'PEARL' Test** – Once health problems have been rated for all criteria, use the 'PEARL' Test to screen out health problems based on the following feasibility factors:
  - Propriety – Is a program for the health problem suitable?
  - Economics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
  - Acceptability – Will a community accept the program? Is it wanted?
  - Resources – Is funding available or potentially available for a program?
  - Legality – Do current laws allow program activities to be implemented?
3. **Calculate priority scores** – Based on the three criteria rankings assigned to each health problem in Step 1 of the Hanlon Method, calculate the priority scores using the following formula:
 
$$D = [A + (2 \times B)] \times C$$
 Where: D = Priority Score  
 A = Size of health problem ranking  
 B = Seriousness of health problem ranking  
 C = Effectiveness of intervention ranking
4. **Rank the health problems**– Based on the priority scores calculated in Step 3 of the Hanlon Method, assign ranks to the health problems with the highest priority score receiving a rank of '1,' the next high priority score receiving a rank of '2,' and so on.

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This document informed by Marni Mason of MarMason Consulting, Lisa McCracken of Holleran Consulting and Leslie Beitsch, courtesy of the Catholic Health Association, The Public Health Memory Jogger, and NACCHO. To access more resources for issue prioritization and community health improvement processes, please visit the CHA/CHIP Resource Center at [www.naccho.org/chachipresources](http://www.naccho.org/chachipresources). For more detailed examples on issue prioritization tools, please see NACCHO's [Guide to Prioritization Techniques](#).

## Prioritization Matrix

	[Strategic issue 1]	[Strategic issue 2]	[Strategic issue 3]	[Strategic issue 4]	[Strategic issue 5]
<b>Importance</b>					
<b>Control</b>					
<b>Serious</b>					
<b>Size</b>					
<b>Effective Actions</b>					
<b>Total</b>					

**Directions:** Decide in advance how many priority areas you feel you can reasonable handle (this can be a range). Replace the column headings with the name of your strategic issues. Individually rate each issue based on the criteria in each row from 1 (low) to 10 (high). Once completed, break into small groups (~5 people) and come up with an average for each variable within each strategic issue. Report out to the larger group, using the same process as within the smaller group. Once completed, total up the scores for each strategic issue. If there's a tie which would create an additional priority area, discuss with your group about how you want to handle this.

**Note:** When used in Kershaw, importance and control were rated as "high", "medium", or "low". When scoring, "high" was converted to a 3; "medium" to a 2; and "low" to a 1.

Criteria
<b>Importance:</b> How important is this issue to the community?
<b>Control:</b> Is this an issue that can be controlled?
<b>Serious:</b> How serious is this issue according to the data (is it killing people, is it costing a lot of money)?
<b>Size:</b> How many people does this issue impact?
<b>Effective Actions:</b> Are there some effective actions that can take place with this issue?

# Supplemental Links

## Strategic Issues Relationship Diagram

When using these diagrams it is important to review the four assessments and begin to pull out data points that have common themes. Write this data at the end of the line extending from the appropriate assessment. Use one sheet per common theme. When complete, review the data you listed and ask “what is the question or problem that is occurring here?” Write the response in the “strategic issue” box. Complete for each sheet. Once complete, discuss what the underlying issue is and how it relates to the group’s vision. Decide on a name for this issue and write it on the line next the “Relationship to vision”.

<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/phase4.cfm>

<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Strategic-Issues-Relationship-Diagram-ppdf.pdf>

<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Chicago-Example-Strategic-Issues-Relationship-Diagram.pdf>

# **Phase 5: Formulate Goals and Strategies**



# Executive Summary



[eatsmartmovemore.org/greenwoodcounty](http://eatsmartmovemore.org/greenwoodcounty)  
[facebook.com/eatsmartmovemoregreenwood](https://facebook.com/eatsmartmovemoregreenwood)

## *Community Assessment Executive Summary and Strategic Plan 2013*

**The vision** of Eat Smart Move More Greenwood County is a Greenwood County in which healthy eating and active living are essential to our community where we live, work, learn, pray, and play.

**The mission** of Eat Smart Move More Greenwood is to make the healthy choice the easy choice.

### Greenwood County Community Profile

Population:	69,840
	66.2% White (69.1% in SC)
	33.8% African American and other (30.9% in SC)
Uninsured	22% (20% SC)
Children in Poverty	29% (28% for SC)
Children in Single Parent HH	46% (39% for SC)
Teen Births	13.6% (12% for SC)
Low Birth Weight	8.8% (9.9% for SC)
Preterm Births	10.7% (11.5% for SC)
Breastfeeding Initiation	50.3% (61.4% for SC)
Adult Obesity	36.9% (32.4% for SC)
Adult Diabetes	10.4% (10.4% for SC)
Adult Hypertension	35% (33.4%)
Physical Inactivity	31.1% (27% for SC)
Not Meeting Fruit and Vegetable Recommendation	83.9% (82.6% for SC)
Limited Access to Healthy Food	5% (8% for SC)
Adult Smoking	23% (20.5% for SC)

### Community Voices (from three sources)

#### ***Self Regional Healthcare Community Assessment Key Informant Interviews and Data Review 2012***

High Impact/High Need:	Access to primary care
High Impact/Medium Need:	Management of diabetes and cardiovascular disease
<b>Medium Impact/High Need:</b>	<b>Rates of obesity, proper nutrition, and physical activity</b>
Medium Impact/Medium Need:	Access to mental health services

#### ***Eat Smart Move More Greenwood County Coalition Agency Partners:***

*Baptist Young Women's Association \* Carolina Health Centers \* City of Greenwood \* Community Initiatives, Inc. \* SCDHEC-Greenwood*

*County \* GLEAMNS \* Greenwood County \* Greenwood County Garden Project \* Greenwood Family YMCA \* Greenwood School District 50 \* Healthy Greenwood Neighborhoods \* Lander University \* The Self Family Foundation \* Safe Routes to School \* Self Regional Healthcare*

### ***ESMM Greenwood Community Survey 2012***

Of 84 respondents, 98% were women, 93% were between the ages of 18 and 34, and 86% were African American.

3.5% had diabetes and 9.5% had hypertension

25% smoked and 13% use smokeless tobacco

Food choices are motivated by availability (13%), price (15%), transportation (8%), and personal preference (56%)

31% exercise 2 days per week and 26% exercise 3 days per week

Main barrier to exercise is lack of time (73%)

### ***Greenwood County Parks and Recreation Master Plan Survey***

Members of the community were asked to evaluate the need for potential parks and recreation facilities. There were 600 respondents who ranked the following as the top 3 needs.

Walking/biking trails, 85.6% rated as needed or strongly needed

Playgrounds, 80.5% rated as needed or strongly needed

Green space and nature preserves, 77.1 % rated as needed or strongly needed

### **Community Health Snapshot (two local sources, compiled from numerous data sources)**

#### ***Self Regional Health Care Assessment 2012***

Key findings in addition to data in the community profile section include:

Greenwood County is projected to have a 2.82% growth in population in the next five years.

There is an anticipated growth of 11.3% in the senior population over age 65 years in the next five years

We rank 16<sup>th</sup> in the state for premature death (years of potential life lost before age 75)

17% have poor to fair health (16% for SC)

Of the population who has low access to a grocery store, 26.6% are kids 0-17 and 14.6% are seniors over the age of 65

Top positive indicators include a moderately high % of women receiving pap smears and very low particulate matter days (air quality)

Top negative indicators include need for internal medicine physicians, very high colon cancer incidence rate, very high breast cancer death rate, and a moderately high colorectal cancer death rate.

### **Local Policy and Environment Review 2013**

Eat Smart Move More Greenwood members gathered information on local policies and environments to support healthy eating, active living, and limiting exposure to second hand smoke.

- Strengths: 18 community gardens with 6 more planned (Update: 22 gardens as of June 2013)  
Lander University, Piedmont Technical College, and SRHC have smoke free campuses  
Complete Streets resolutions passed in Greenwood and Ninety Six
- Opportunities: No schools currently participate in Farm to School  
One of three school districts (District 51) has adopted a model tobacco policy

### **Forces of Change 2013**

Twelve community members from local agencies, neighborhoods, and government met to discuss and identify forces of change for Greenwood County as it relates to health and quality of life. Threats and opportunities listed which can be addressed locally include

#### **Threats**

- Excessive screen time by children and adults
- Lack of community walkability
- Cultural values toward healthy lifestyles
- Personal values and priorities
- Lack of knowledge of chronic disease prevention

#### **Opportunities**

- Educate families and children on healthy eating, active living, and tobacco risk
- Improve quality of family time by increasing healthy options in social, church, school, and work settings
- Apply Complete Streets concepts
- Increase number of and access to neighborhood parks
- Promote local farm products

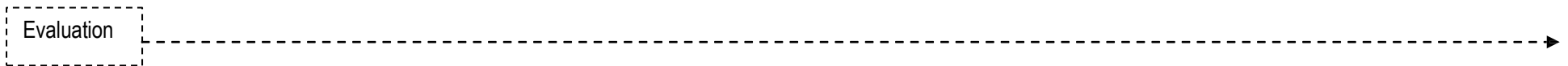
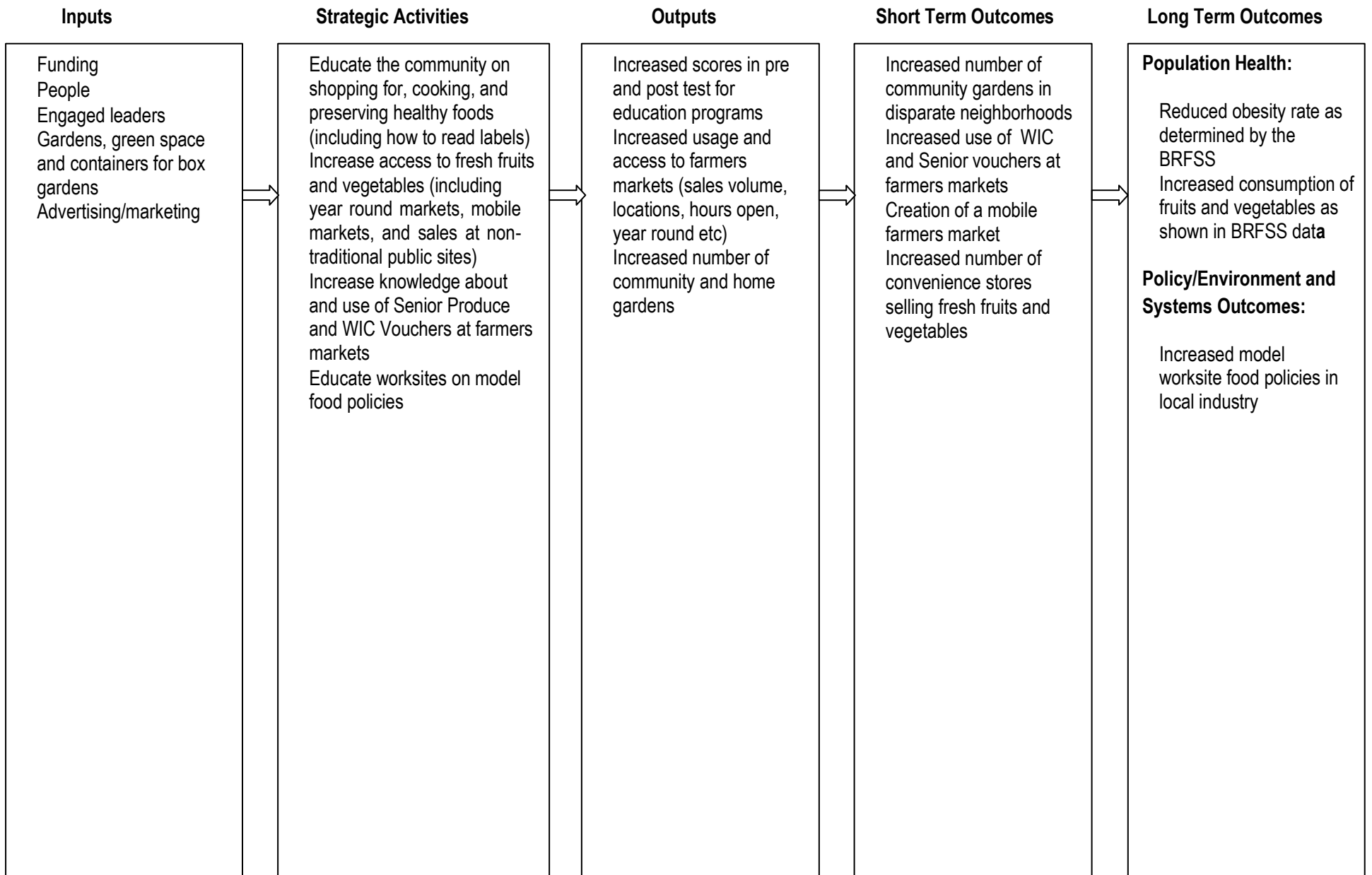
### **Strategic Issues Assessment 2013**

Key strategic issues/strategies were identified by community members that participated in the forces of change assessment. The key strategic issues/themes that emerged from this assessment component include

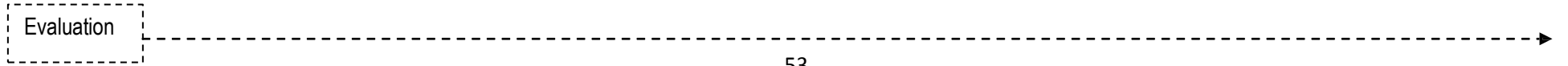
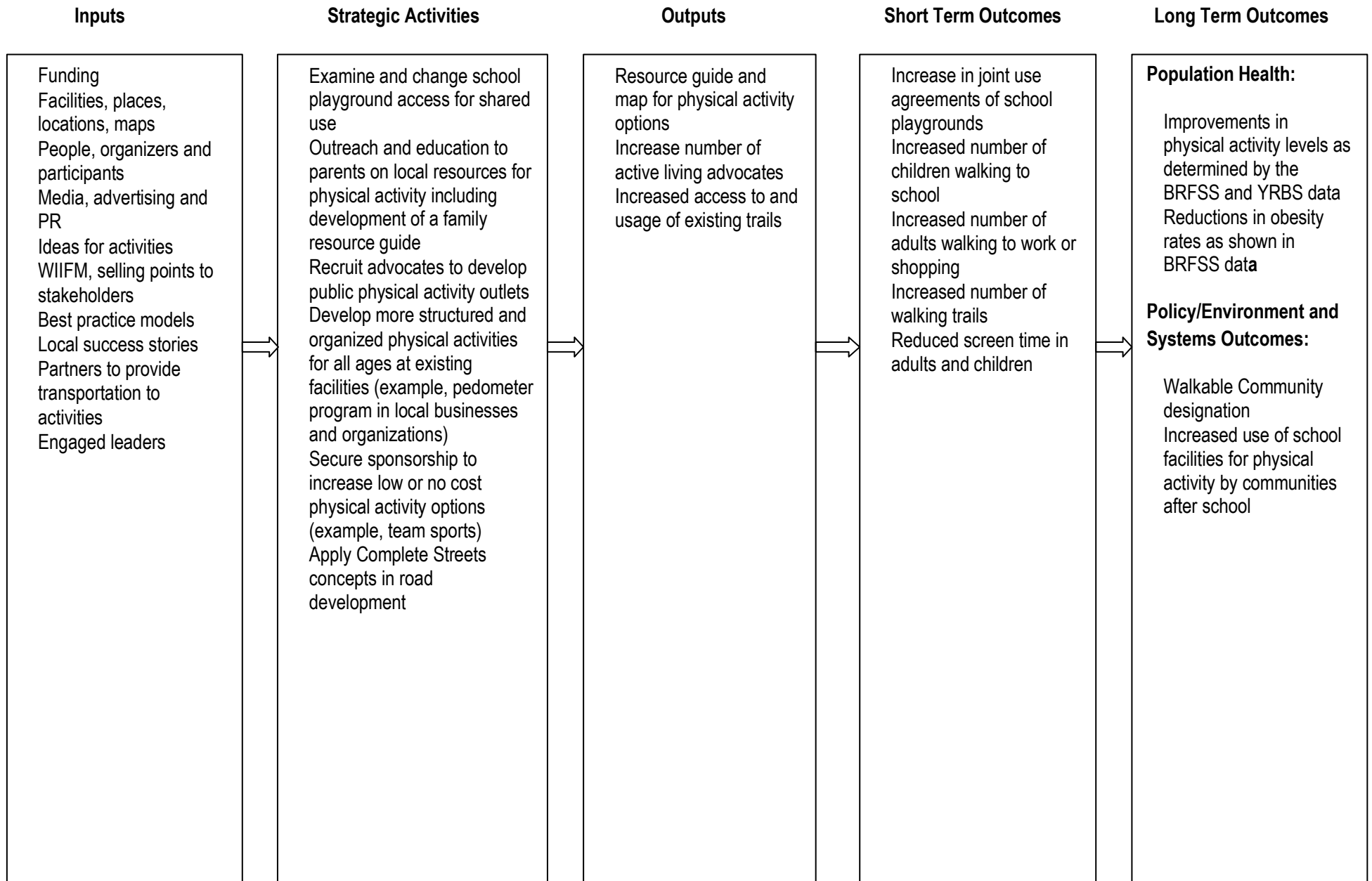
- Access to fresh fruits and vegetables for everyone
- Knowledge of what is healthy eating and how to cook healthy foods
- Access to safe bike and pedestrian routes on streets and trails
- Opportunities for structured and unstructured physical activity
- Reducing exposure to second hand smoke

Coalition and community members also worked on a five year strategic plan for health eating, active living, and reducing exposure to second hand smoke.

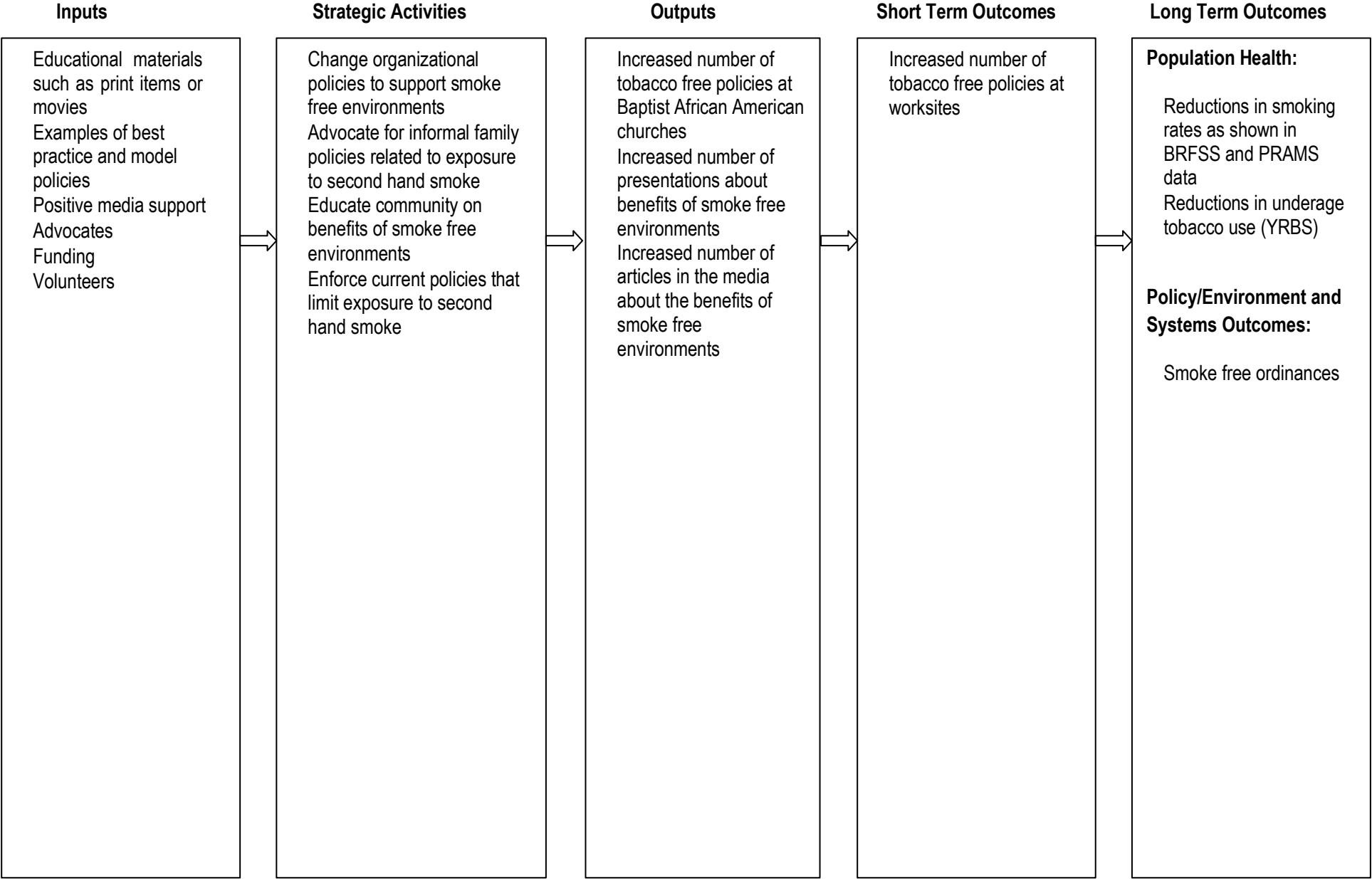
## Healthy Eating Strategic Plan for Greenwood County May 2013



## Active Living Strategic Plan for ESMM Greenwood County May 2013



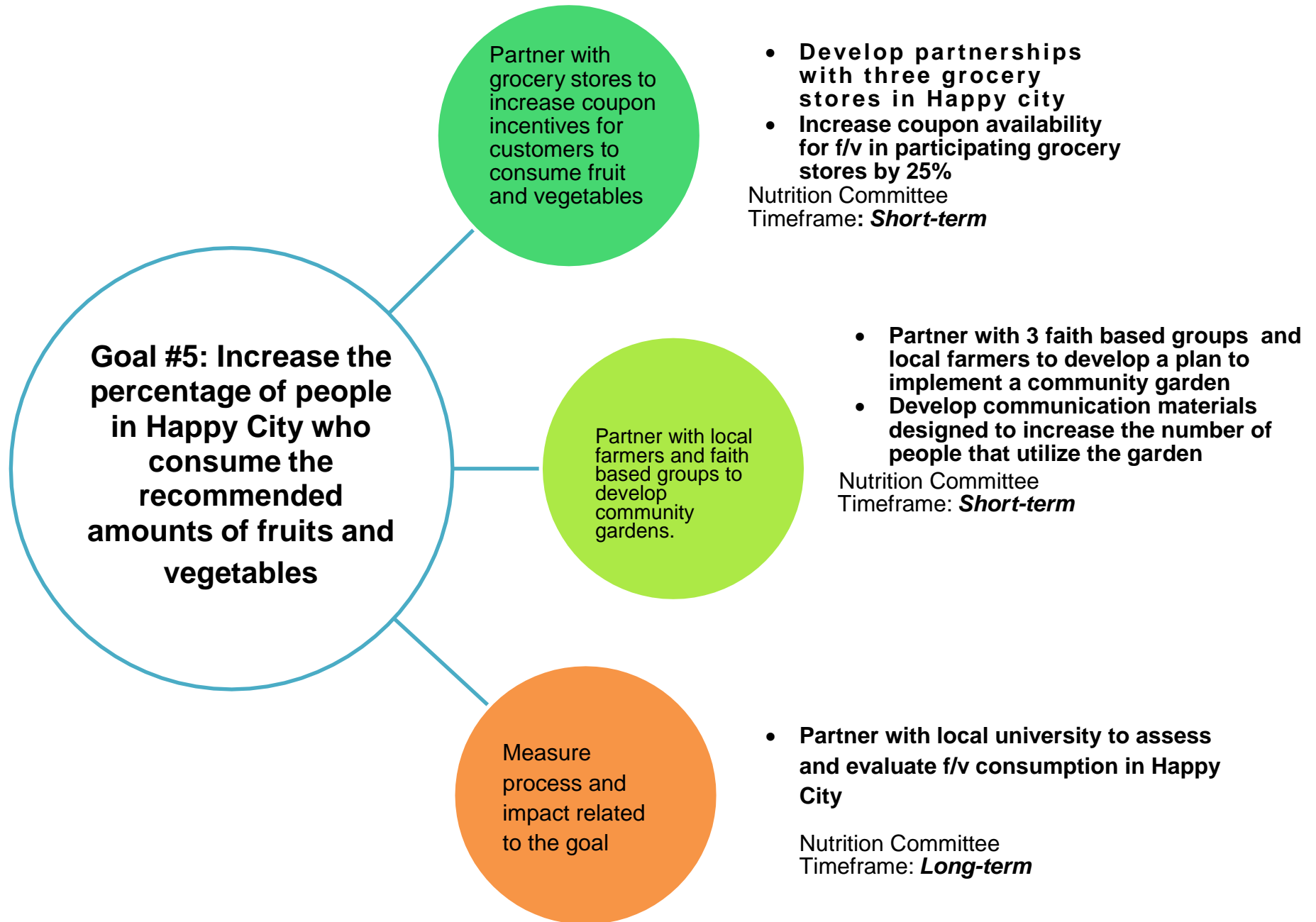
**Reducing Exposure to Second Hand Smoke  
Strategic Plan for Greenwood County May 2013**



# **Phase 6: The Action Cycle**



The following graphics are ways that strategic issues could be displayed.



# Other Resources

## GALLERY WALK

### What is it?

- A collaborative brainstorming and discussion method that moves small groups of people from station to station on a rotating basis as a way to gather and record input.
- This works best for a group of 20 to 30 participants.

### What can I use it for?

- Gathering input for the community voices component of an assessment
- Identifying strategic issues in a community
- Identifying evidence based strategies or actions steps for a plan or its implementation

### What resources do I need?

Flip chart paper, 2 markers for each station, masking tape, voting dots, sign in sheet, name badges

### What do I need to do ahead of the meeting?

- Determine the time frame. Allow at least 2 hours, though this will depend on the purpose, number of topics, and number of participants.
- Determine the topics for discussion. You should plan for 3-6 people at each station so a group of twenty could be divided into 4 groups of 5. That will mean you have 4 topics. You could have fewer or more topics depending on the purpose of the brainstorming.
- Develop some prompts to help people think about information being gathered. This can be placed on flip chart paper to post at the session.
- Reserve a room with adequate free wall space to put up flip chart paper. This is a standing exercise. If standing is an issue for participants, chairs can be placed at each station.
- Determine the ground rules and prepare an overview to explain the purpose of the session.
- Label flip charts in advance of the meeting to reduce set up time the day of the event.
- If voting to set priorities, cut voting dots into the # of votes each participant will have and rubber band them together.
- Prepare a sign in sheet.

### What is the flow at the event?

- Arrive early. Place the flip chart paper labeled with topics on the walls with some separation between stations. Put up an additional paper at each station and label it with the topic and page # so that you can keep comments organized for later transcription. Keep extra paper on hand to add additional sheets if needed during the gallery walk.
- Set up the registration table.

- Start the session. Do introductions, explain the purpose of the session, explain the process for the gallery walk, and explain the ground rules.
- Have participants count off by the number of stations. Then tell each numbered group what station to report to. Each group should have 2 markers. Allow them 15-20 minutes to discuss and record their input on the flip chart paper. Monitor discussion and give a one minute warning to allow people to complete a thought and record it. TIP: If you want to identify input by small group, let each group have a different color marker. That can help during the clarification phase.
- Call time and have them rotate to the next station. The group will then review prior comments listed at the new station and add to them. TIP: You can slowly decrease time at each station as discussion slows. You do not have to have all groups go to each station if you have a tight schedule. However, people may feel cheated if they don't get to comment on all topics.
- The facilitator needs to walk around and help the groups stay on task but should remain neutral and not give input. Sometimes groups fail to capture key points and you can encourage them to record them. Sometimes groups get stuck and the facilitator can ask probing questions. Encourage input from silent participants. Discussion usually slows down as groups move through stations. For large groups you may wish to have additional facilitators.
- When all stations have been visited by each group take a break. If you have not already done so, pass out the voting dots. Come back and process the information collected by reading each entry and asking for clarification of items recorded. You may find you need to move an item to another topic. You may also combine like items into one. Rewrite if needed for clarity and draw a line through things that have been moved or rewritten. This will be helpful during voting.
- When the large group feels it understands the items recorded, ask them to use their dots to vote for their top picks from the lists. Tally the votes and briefly discuss. Top picks might be recorded on a separate flip chart paper if you are continuing with use of that information at the event.
- Thank the group for their input and discuss next steps.

### **What do I do after the event?**

Transcribe all input into a report to document the data collected for use in planning. This document should be shared with groups who are analyzing assessment data or developing the plan.

## **Bicycle and Pedestrian Task Force Handlebar Assessment**

**Date:** Tuesday, November 22, 2011

**Purpose and Background:** The Bicycle and Pedestrian Task Force assessed the built environment around Winthrop University and Downtown Rock Hill as well as key connector routes by analyzing the opportunities and constraints of providing accommodations for bike travel on the designated roadways.

**Justification:** Current conditions are unsafe for students and residents who choose to bike and walk to and from the Winthrop University area and adjoining neighborhoods. A bicycle audit survey conducted by the Bike Ped Task Force in 2010 revealed that over 80% of respondents would choose to ride their bikes more often if conditions were safer. Calming speeds, installing bike lanes or sharrows and reducing travel lanes, if feasible, on certain roads will provide a safer environment not only for pedestrians and cyclists, but motorists as well. Providing a built environment that supports all modes of travel enhances livability, improves public health and safety, and encourages economic development. These improvements support the College Town Action Plan, 2020 Comprehensive Plan, PRT Master Plan and ACHIEVE.

### **Roads Assessed:**

Oakland Avenue from Black Street to McDow Drive

Charlotte Avenue from McDow Drive to Black Street White

Street from Charlotte Avenue to Columbia Avenue Wilson

Street from Charlotte Avenue to Johnston Street

Stewart Avenue from Constitution Boulevard to Oakland Avenue

Columbia Avenue from Alumni Drive to Constitution Boulevard Cherry

Road from Constitution Boulevard to Richmond Drive Constitution

Boulevard from Cherry Road to Main Street

Main Street from Constitution Boulevard to Dave Lyle Boulevard

## Oakland Ave – Black St to Stewart Ave



### **Opportunities:**

- Alternative engineering roadway designs to accommodate for bicycle facilities. There is enough space (currently about 48') for dedicated bike lanes and one 12' travel lane on both sides with divided left turn medians. Use Charlotte's Urban Streets Design Guidelines to determine possible solutions for both motorists and active transportation users
- Appealing road for bicycle and pedestrian users allowing direct connections between Winthrop to multiple bike shops and Downtown
- Serve as the interim primary bicycle route between Winthrop and Downtown
- Reduction in vehicular speeds calms traffic down for additive safety for bicyclists and pedestrians

### **Constraints:**

- Owned by SCDOT, need to enhance partnership
- On-street parking on Sundays served as church parking
- High travel speeds

## Oakland Ave – Stewart Ave to Cherry Rd



### **Opportunities:**

- Serve as the interim primary bicycle route between Winthrop and Downtown, and bike compatible with sharrow markings
- Alternative engineering roadway designs to accommodate for bicycle facilities. There is enough space (currently about 49') for dedicated bike lanes and one 12' travel lane on both sides with divided left turn medians. Use Charlotte's Urban Streets Design Guidelines to determine possible solutions for both motorists and active transportation users
- Provides alternative modes of transportation to connect students, faculty and staff with nearby neighborhoods, retail and restaurants
- Reduction in vehicular speeds calms traffic down for additive safety for active transportation users
- Appealing road for bicycle and pedestrian users allowing direct connections between Winthrop's main entrance to multiple bike shops and Downtown

### **Constraints:**

- Additional partnerships with Winthrop and SCDOT to accommodate for bicycle facilities
- Currently, road width too narrow for dedicated bike lanes and four vehicular travel lanes through this section as well as at the Cherry Road intersection; Need of specialized multi-modal consultants to analyze the intersections and roadway design for bike compatibility. Use Charlotte's Urban Streets Design Guidelines to determine possible solutions for both motorists and active transportation users
- Not pedestrian or bicycle friendly at Cherry Road intersection because of high travel speeds and traffic volumes

## Oakland Ave/India Hook Blvd – Cherry Rd to McDowell Dr and Herlong



### **Opportunities:**

- Wide road widths (64' from Cherry Road to Ebenezer Road and 42' from Ebenezer Road to McDow Drive) to allow ample space for dedicated bike lanes, one 12' travel lane on both sides and left turn median
- Provides direct connection to Westminster, Fewell Park and other abutting neighborhoods, and activity centers at intersections of Herlong Avenue and Cherry Road
- Reduction in vehicular speeds calms traffic down for additive safety for bicyclists and pedestrians
- Faded road markings provide opportunity for restriping project to include bike lanes or sharrows

### **Constraint:**

- High travel speeds makes it unsafe for active transportation users
- Owned by SCDOT, need to enhance partnership

## McDow Dr – India Hook to Charlotte Ave



### **Opportunities:**

- Wide travel lanes (36') to accommodate for dedicated bike lanes
- Needs repaving along curb provides opportunity for restriping the road to include bike facilities
- Low posted speed limit and traffic volumes
- Connects Fewell Park and Beaty Estate neighborhoods





***Opportunities:***

- Provides connection between Westminster, Beauty Estates, retail and restaurants at the intersections of North Avenue and Cherry Road
- Wide travel lanes (44' to 46') to accommodate for dedicated bike lanes
- Entering into the business district around North Avenue, travel lane width on the west side abutting the businesses is wide enough for bike lane and on-street parking
- Existing striping is fading and could be earmarked immediately for re-striping to include bike lanes and on-street parking
- Including bike lanes will provide additional buffer between motorist and pedestrians
- Reduce travel speeds from 35 mph to 25 mph to calm motorist speeds for additional safety

***Constraints:***

- On-street parking on the east side of Charlotte Avenue that would abut the existing single-family homes needs to be evaluated to include both on-street parking and bike lane
- High travel speeds
- Owned by SCDOT, need multi-jurisdictional partnership